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Misinformed Consent: Non-Medical Bases for American Birth Recommendations as a Human-Rights Issue

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as a Human-Rights Issue

by

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Abstract. A significant number of American women receive clinical birthing-option advice from obstetrician-gynecologists ("ob-gyns") that is based at least in part on non-medical considerations, without being informed of the non-medical bases that influence the recommendations they receive. The first premise of this paper is that the provision of medical advice in this manner constitutes a human-rights violation under both international and American human-rights norms. The second premise of this paper is that these violations may be averted or alleviated by greater transparency in American medical-services provision, particularly with reference to establishment of clinical practice standards by the American College of Obstetricians and Gynecologists (hereinafter "ACOG"), and by increasing ob-gyn accountability via litigation.

These premises are examined first generally, and then with particular regard to the formalized but non-governmental facilitation and encouragement of delivery of fetuses by cesarean section -- a surgical procedure – via restriction of the availability of medical services in support of vaginal birth by women who have previously delivered by c-section ("VBAC," or vaginal birth after cesarean).

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What we see [in obstetrics units] resembles childbirth as much as artificial insemination resembles sexual intercourse.
Ronald Laing, Psychiatrist

A significant number of American women receive clinical birthing-option advice from obstetrician-gynecologists ("ob-gyns") that is based at least in part on non-medical considerations, without being informed of the non-medical bases that influence the recommendations they receive. This professional custom may cause various adverse consequences to the women who receive such recommendations. These adverse consequences include: a) impairment of a woman's ability to consent to or refuse surgery or other treatment in an informed manner; b) reduction in availability of services; and c) restraint of qualified non-obstetrician providers. These providers include nurses, midwives and family practice physicians. Importation of undisclosed non-medical considerations into the formulation of birthing recommendations also subverts established American policy in favor of the reduction of surgical delivery of babies,[1] and against restraint of trade in the health-care field.[2]

The first premise of this paper is that the provision of medical advice in this manner constitutes a human-rights violation under both international and American human-rights norms. The second premise of this paper is that these violations may be averted or alleviated by greater transparency in American medical-services provision, particularly with reference to

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[1] *See, e.g.*, US Department of Health and Human Services, Public Health Service. *Healthy People 2000*. DHHS Publication No. 91-50213. Washington, DC: US Government Printing Office: 1991:378-379 (establishing c-section goal of 15%); *Cesarean Childbirth*. Report of a Consensus Development Conference. NIH Publication No 82-2067; Bethesda, MD: Department of Health and Human Services; 1981 (Consensus Development Conference on Cesarean Childbirth of the National Institute of Child Health and Human Development convened in 1979 to sound alarm over then record high American cesarean birth rate of 15%, which later rose to approximately 25%, highest by far of any industrialized country).

establishment of clinical practice standards by the American College of Obstetricians and Gynecologists (hereinafter "ACOG"), and by increasing ob-gyn accountability via litigation.

These premises are examined first generally, and then with particular regard to the formalized but non-governmental facilitation and encouragement of delivery of fetuses by cesarean section -- a surgical procedure – via restriction of the availability of medical services in support of vaginal birth by women who have previously delivered by c-section ("VBAC," or vaginal birth after cesarean).

Comparative assessment of the clinical risks and benefits of various birthing methods, locations and care providers is beyond the scope of this paper (and beyond the qualifications of the author). Health factors specific to a particular woman or baby, *i.e.*, maternal age at first birth, confirmed parental genetic risks, individual history of illness or surgery, and other patient-specific medical issues are not evaluated.

Rather, the focus of this paper is the human-rights implications of birthing recommendations that are based at least in part on *non-clinicial*, that is, non-medical factors not specific to any given individual. These factors include the larger economic context, particular financial rewards or disincentenives from the provider point of view, the potential for legal liability flowing from a given clinical decision, and political and social pressures of various types that arise not from the clinical presentation of any one individual, but from the broader environment of social conflict.

The International Human-Rights Context

The United States is one of the most dangerous places in the industrialized world to give birth.
M. Myers, M.D.

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[2] *See, e.g.*, Sherman Act, 15 U.S.C. §§ 1-11 (1988).

"All human beings are born free and equal in dignity and rights. … Everyone has the right to recognition everywhere as a person before the law."[3] Many prescriptive or proscriptive human-rights norms relate specifically to provision of health care. The Universal Declaration of Human Rights (Article 25) provides: "Everyone has the right to a standard of living adequate for … health and well-being". Various international documents shed light on the evolving "right" to health, which has been recognized to various degrees, in many different formulations, from country to country and by the international community.

The United States often refrains from becoming a party signatory to a treaty that provides for the so-called "social and economic rights," as opposed to the "civil and political rights" on which the U.S. is historically founded. This results in denial of direct enforcement power to American courts of law. Nonetheless, evolving international norms – as reflected in treaties, international custom, and pronouncements from respected international organizations such as the United Nations, the World Health Organization, the World Court, and the European Court of Human Rights -- are powerful persuasive authority on the appropriate treatment of human beings.[4]

International standards are evidence of what the U.S. Supreme Court has called "values we share with a wider civilization."[5] Any individual in any country may cite these norms in defense of their rights, as they reflect the expectations of relevant actors in the international arena, that is, the subjects of both national and international law: individual human beings.[6]

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[3] Universal Declaration of Human Rights, 3 U.N. GAOR, G.A. Res. 217, U.N. Doc. 1/777 (1948).
[4] The history and sources of international human rights are beyond the scope of this paper. For purposes of the instant discussion, international human-rights norms are presumed to have at least persuasive force. Often they also carry enforcement authority in various national fora.
[5] *Lawrence v. Texas*, 539 U.S. 558, 575 (2003).
[6] *See, e.g.*, Harold D. Lasswell & Myres S. McDougal, *Jurisprudence for a Free Society: Studies in Law, Science and Policy* (1992); Siegfried Wiessner & Andrew R. Willard, "Policy-Oriented Jurisprudence and Human Rights Abuses in Internal Conflict: Toward a World Public Order of Human Dignity," 93 *American Journal of International Law* pp. 316 *et seq.* (1999); W. Michael Reisman & Eisuke Suzuki, "Recognition and Social Change

A right to health is identified in the International Covenant on Economic, Social and Cultural Rights (Article 12), which states that the more than one hundred fifty subscribing countries "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". At the international level, compliance with the Covenant is tracked by the Committee on Economic, Social and Cultural Rights. In the year 2000, the Committee issued a "General Comment" elucidating the right to health.

The Comment is accorded substantial respect as an authoritative statement of the Covenant by those charged with its implementation. The Comment interprets the right to health as a web of related freedoms and entitlements, which include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. The entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

The World Health Organization ("WHO") – affiliated with the United Nations – defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". What's more, "the right to health should be understood as extending beyond health care to access to health-related education and information, including on sexual and reproductive health." The Committee has developed a set of criteria for assessing whether health

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in International Law: A Prologue for Decisionmaking," *printed in* W. Michael Reisman & Burns H. Weston (eds.), *Toward World Order and Human Dignity: Essays in Honor of Myres S. McDougal* pp. 403 *et seq*. (1976); Myres S. McDougal, Harold D. Lasswell & W. Michael Reisman, "The World Constitutive Process of Authoritative Decision," 19 *Journal of Legal Education* pp. 253 *et seq*. (1967), reprinted in Richard A. Falk & Cyril E. Black (eds.), 1 *The Future of the International Legal Order* 73 (1969); Myres S. McDougal, W. Michael Reisman & Andrew R. Willard, "The World Community: A Planetary Social Process," 21 *U.C. Davis L.Rev.* pp. 807 *et seq*. (1988); Myres S. McDougal & W. Reisman (eds.), *Power and Policy in Quest of Law*, (1985); W. Michael Reisman, "International Lawmaking: A Process of Communication," *Proceedings of the American Society of International Law* pp. 101 *et seq*. (1981); Siegfried Wiessner & Andrew R. Willard, "Policy-Oriented Jurisprudence and Human Rights Abuses in Internal Conflict: Toward a World Public Order of Human Dignity," 93 *American Journal of International Law* pp. 316 *et seq*. (1999).

facilities and services are compatible with human rights principles. One criterion is accessibility of information, including the right to seek, receive and impart information, consistent with confidentiality of personal data.[7]

Certain international norms relate specifically to women's health issues. For example, the Convention on the Elimination of All Forms of Discrimination against Women requires those countries which are parties to the treaty to "take all appropriate measures to eliminate discrimination against women…in particular to ensure…access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning" (Article 10). Children are accorded similar recognition in the international Convention on the Rights of the Child (Article 24): "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."

The Preamble to the Constitution of WHO provides: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The Convention on the Rights of the Child requires subscribing countries to "take appropriate measures to ensure appropriate pre-natal and post-natal health care for mothers".

According to Amnesty International, there is an increasing body of international human rights law and commentary which sets out in authoritative terms the requirements of states to protect women's sexual and reproductive rights.[8]

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[7] *See generally* Amnesty International, "Caring for human rights: Challenges and opportunities for nurses and midwives," Amnesty International Index: ACT 75/003/2006 (June 2006).

[8] *See, e.g.*, Amnesty International, "Caring for human rights: Challenges and opportunities for nurses and midwives," Amnesty International Index: ACT 75/003/2006 (June 2006).

The National Human-Rights Context

In the U.S., women often encounter gender bias in diagnosis and treatment.[9] General cultural and societal bias also play a role in influencing the quality of care women receive.[10] A pervasive societal bias in the United States is "the fantasy of omniscience and omnipotence, as embodied in the doctor who commands the wondrous apparatus of modern science, [and] the fantasy of ignorance and weakness, as embodied in the uncertain, dependent patient."[11]

Nonetheless, there are many pertinent enforceable legal norms. The U.S. Constitution is generally perceived as the acme of our legal authority. Many judicial cases inform federal constitutional protection as they relate to giving birth. Broader doctrines premised on bodily autonomy may be invoked in relation to pregnancy, labor and delivery, though the doctrines may have arisen initially in other settings.

The right to refuse treatment is illustrative. Absent imposition of a court-ordered medical guardian, the individual patient herself must be consulted for her informed consent regarding surgical procedures and other treatment. Federal courts have acknowledged what they call the "intuitively obvious proposition" that "a person has a constitutionally protected interest in being

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[9] *See, e.g.*, Michelle Oberman & Margie Schaps, Women's Health and Managed Care, 65 TENN. L. REV. 555, 580 1998 (noting that "the mere increased representation of women in clinical trials and the handful of federally-funded studies on health issues specific to women will not `cure' the problems emanating from a research structure that is accustomed to treating men as the norm and women as the exception."); Mary Lake Polan, Medical Researchers, Heal Thyselves of Gender Bias, L.A. TIMES, Feb. 24, 1991, at M2; Bruce A. Bergelson & Carl L. Tommaso, Gender Differences in Clinical Evaluation and Triage in Coronary Artery Disease, 108 CHEST 1510, 1510 (1995) (concluding that a gender-based selection bias exists in choosing patients to undergo cardiac procedures); Tiffany F. Theodos, "The Patient's Bill of Rights: Women's right under managed care and ERISA preemption," American Journal of Law and Medicine, Vol. 26, Iss. 1, pp. 89-109 (2000).

[10] Tiffany F. Theodos, "The Patient's Bill of Rights: Women's right under managed care and ERISA preemption," American Journal of Law and Medicine, Vol. 26, Iss. 1, pp. 89-109 (2000); Michelle Oberman & Margie Schaps, Women's Health and Managed Care, 65 TENN. L. REV. 555 (1998).

[11] Brodsky book, intro p. xxix.

left free by the state to decide for himself whether to submit to … serious and potentially harmful medical treatment."[12]

Even persons subject to a guardianship are entitled to legal review prior to being subject to unwanted treatment and surgical intervention. A burden of proof must be carried by the proponent of the treatment, namely, that: 1) the affected individual would, if mentally competent, accept the treatment; or 2) that there is a sufficiently important state interest which would override the individual's refusal.[13] The US Supreme Court has rooted the basis of these requirements in the due-process protection afforded by the Fifth Amendment to the U.S. Constitution.[14]

Forging ahead to administer unwanted treatment to a person without observing these requirements has been described as a "massive curtailment of liberty".[15] These fundamental constitutional principles have been invoked to analyze the propriety of surgical and other medical interventions during pregnancy, labor and delivery.[16]

For example, a pregnant woman named Angela Carder refused to consent to a c-section despite the fact that she had cancer. Hospital officials sought and obtained a court order approving surgical delivery of the fetus before administering cancer treatment. The attending physicians subjected Ms. Carder -- who had not been adjudicated mentally incompetent (nor was

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[12] *See, e.g., Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), *vacated and remanded other grnds sub nom Mills v. Rogers*, 457 U.S. 291 (1982).

[13] *E.g., In re Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40, 61 (1981) (interpreting constitutional liberty interest pertaining autonomy of the body).

[14] *E.g., Mills v. Rogers*, 457 U.S. 291, 303 (1982).

[15] *In re W.H.*, 144 Vt. 595, 599, 481 A.2d 22 (1984).

[16] The legal and social controversy surrounding abortion is outside the scope of this paper. For instant purposes, it should be noted that legal challenges to abortion or restrictions on abortion typically involve the criminalization of an individual seeking to subject herself to a medical procedure that itself is the subject of condemnation by certain parts of society. Forcible cesarean section, on the other hand, involves subjection of a woman to a medical intervention to which she is opposed, thereby invoking autonomy and privacy interests not present in the case of abortion. It is the difference between society withholding a procedure desired by a woman, and forcing a woman to

she alleged to be) – to the unwanted surgery. Both Ms. Carder and her baby died. In a rare posthumous ruling, the federal appeals court held on constitutional grounds that a pregnant woman had the right to make all medical decisions on behalf of herself and her fetus, noting that parents of born children could not, by law, be forced to donate organs to their children or otherwise undergo surgery to benefit existing children.[17] The court also ruled that the state's interest in the viability of the fetus and in preventing any potential harm the mother might cause to it by refusing treatment does not override her fundamental right to bodily integrity and to refuse treatment.[18]

Another pregnant woman refused a blood transfusion, prompting hospital officials to seek and obtain a court order for forced transfusion. This time the Court declined the provider's request, instead upholding the woman's right to refuse the treatment in question despite the fact that she was pregnant.[19]

At the federal legislative level, the Emergency Medical Treatment and Active Labor Act[20] prohibits hospitals and doctors from turning away a woman in active labor, who has approached within 250 feet of a hospital building, until she is stabilized. With regard to labor, stabilization means delivery of the fetus and placenta.[21]

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be subject to a procedure she does not want. This distinction has important legal ramifications within constitutional jurisprudence.

[17] *In re A.C.*, 573 A.2d 1235 (D.C. 1990).

[18] The constitutional jurisprudence of pregnancy termination is distinct, as noted elsewhere.

[19] *In re Baby Boy Doe*, 260 Ill. App. 3d 392; 632 N.E.2d 326; 1994 Ill. App. LEXIS 501; 198 Ill. Dec. 267 (Ill.App. 1st Dist. 1994).

[20] 42 U.S.C. 1395dd.

[21] *See also* Wagner, M., *Born In the USA: How A Broken Maternity System Must Be Fixe To Put Women And Children First*, University of California Press, Berkeley, 2006, p. 177.

The constitutions or statutes of any given state in the United States may recognize liberty interests more extensive than those independently protected by the federal Constitution.[22] A survey of relevant state jurisprudence is beyond the scope of this article. Suffice it to say, for instant purposes, that no state is at liberty to provide lesser protections than those afforded at the federal level.

Finally, state common law may afford some protections to pregnant women as to any other person receiving medical care, in the form of civil malpractice lawsuits or complaints to medical boards, or both. For instance, in 2005 a Massachusetts woman sued her health-care providers for performing an unwanted c-section on her, contrary to her previously-stated preference for a VBAC. The jury found that the surgery was not medically necessary, and resulted in physical injuries that left the mother largely bedridden for several years, and unable to perform normal life tasks. The mother was awarded $1.5 million for the violation of her rights, and costs associated with her resultant injuries and home-care needs.[23]

Giving Birth As An American Human-Rights Issue

A woman is a uterus surrounded by a supporting organism.
I. Gladstone, Obstetrician

The human-rights aspect of some birthing issues is palpable at a glance -- for example, the penal practice of shackling prisoners during labor and delivery. In 2006 the United Nations Committee Against Torture issued a report condemning this continuing American practice as a form of torture.[24]

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[22] *E.g., Best v. Department of Health*, 149 NC App. 882 (2002); *Bethea v. Springhill Memorial Hospital*, 833 So.2d 1 (Ala. 2002).
[23] *Meador v. Stahler and Gheridian*, Meador v. Stahler and Gheridian (Middlesex Superior Court C.A. No. 88-6450, Mass. 1993).
[24] United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, GENERAL CAT/C/USA/CO/2, 25 July 2006, Thirty-sixth session.

Other birthing practices, however, require some analysis to reveal their questionable nature vis-à-vis human rights. In the United States, most births occur in hospitals, with obstetricians attending. In many other highly developed countries, however, including the United Kingdom, Sweden, Denmark, and Japan, midwives attend most births and far outnumber obstetricians. A brief historical look is illuminating.[25]

Throughout most of history, the primary care providers at birth were midwives. Midwives attended almost all births in the American colonies,[26] relying on skills learned in their British homeland and passing them along. Slavery effectively imported midwives from West Africa, who attended births of both black and white women in certain southern states. This engendered a post-civil-war legacy of African-American midwives in most rural parts of the South, where they were referred to as "granny midwives" and tended laboring poor women of various races. American Indian tribes had their own midwives and midwifery traditions, now mainly limited to work on reservations.

With its fragmented and rural character, the United States predictably developed significant variation in midwifery practices and laws. There were few midwifery schools, and virtually no legal regulation of the practice of midwifery (or medicine, for that matter) throughout much of American history. With midwives tending primarily to poor, rural women – who lacked ready access to doctors willing or able to attend them – there was little motivation to outlaw midwives, who thus practiced in most states without government control or physician resentment until the 1900s.

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[25] The author is indebted to a number of sources for this overview of birth history in America. *E.g.*, Rooks, Judith, *Our Bodies, Ourselves* (2005), in particular Chapter 22, "The History of Childbearing Choices in the United States," reprinted at http://www.ourbodiesourselves.org/book/companion.asp?id=22&compID=75 (last updated December, 2006); Gaskin, I.M., *Ina May's Guide to Natural Childbirth* (Bantam Books: New York 2003); Rooks, J., *Midwifery and Childbirth in America* (Temple University Press: Philadelphia 1997).

[26] Although a physician in Staunton, Vermont is believed to have performed the first American c-section, on his wife, in the 1790s.

In the latter half of the nineteenth century, American medicine started to become professionalized, with concomitant financial rewards for its practitioners, who gladly incorporated burgeoning technology and the nineteenth-century spirit of innovation into their practices. At roughly the same time, large segments of the American population shifted from rural to urban settings, placing more and more pregnant women physically within reach of doctors and hospitals. This set the stage for the on-going conflict, often bitter, between physicians and midwives that we observe in this country to the present day.

By the beginning of the 20th century, midwives attended only about half of all births in the U.S., and physicians attended the other half. Scholars have consistently identified economic competition, professional and institutional needs to hospitalize birth, and gender discrimination as factors contributing to this profound shift in maternity-care service providers.[27]

The shift to physician-dominated birthing attendance became ever-more extreme as the twentieth century progressed, culminating in an almost-complete usurpation of the traditional role of the midwife by doctors, and giving rise to the pathology-oriented medical model of childbirth that obtains in the U.S. to the present day. Major events in this historical paradigm shift include two reports on medical education, published in 1910 and 1912, that identified significant deficiencies in American obstetrical training, and ironically recommended remedying the situation with the gradual abolition of midwifery, and hospitalization for all deliveries.

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[27] *See, e.g.*, Barbara Bridgman Perkins, *The Medical Delivery Business: Health Reform, Childbirth, and the Economic Order*, (Rutgers University Press, New Brunswick, NJ 2004:31); Davis-Floyd, R., *Mainstreaming Midwives: The Politics of Change*, Routledge, New York 2006, pp. 32-33; Wagner, M., *Born In the USA: How A Broken Maternity System Must Be Fixe To Put Women And Children First*, University of California Press, Berkeley, 2006, pp. 13-36.

Rather than give birth at home in the company of a midwife, the report argued, poor women should attend charity hospitals to provide training opportunities for doctors.[28]

These influential reports – issued in a country in the throes of a love affair with progress, technology, science and chemistry -- were followed a few years later by the introduction of "twilight sleep" in 1914. Twilight sleep was induced through a combination of morphine, for relief of pain, and scopolamine, an amnesiac that caused women to have no memories of giving birth. Upper-class women initially welcomed twilight sleep as a symbol of medical progress, although its negative effects were later publicized. The opinion of lower-class women on the subject, imported into charity hospitals as training subjects for the new medical specialty of obstetrics, is not recorded.

Thus the seeds for bitter conflict were sown early in the twentieth century between obstetricians – virtually all of them male, and eager to ply their ever-growing surgical and technological skills – and midwives, virtually all of them female, already being marginalized by exclusion from the scientific fraternity. According to a leading commentator on the subject:

> Starting in the early 1900s, physicians [who were] determined to take charge of childbirth … waged systematic and virulent propaganda campaigns against the thousands of immigrant midwives practicing in the northeastern cities, as they were seen to be the greatest threat to physicians' attempts to take control of birth. These campaigns employed stereo-types of midwives as dirty, illiterate, ignorant, and irresponsible, in contrast to hospitals and physicians, which were portrayed as clean, educated, and the epitome of responsibility in health care. …
>
> Cultural, socioeconomic, and language barriers contributed significantly; even professional immigrant midwives usually served only their own communities and were often not aware of the existence of other midwives serving other communities one neighborhood away. Other impediments to organization [of midwifery] included legal and cultural prohibitions against women regarding public speaking, leadership, finances, and so forth …. So in spite of the high level of training many immigrant midwives obtained in professional European midwifery programs and their extensive experience, it

[28] *E.g.*, Rooks, Judith, "The History of Childbearing Choices in the United States," *Our Bodies, Ourselves* (2005), reprinted at http://www.ourbodiesourselves.org/book/companion.asp?id=22&compID=75 (last updated December, 2006).

> was easy for the medical profession to portray them as untrained and ignorant, and impossible for them to combat these stereotypes in the wider cultural arena.[29]

With simultaneous destruction of traditional competition, burgeoning of medical technology, and urbanization of the American population, the die was cast for American birthing practices for the next century. The new philosophy was articulated most famously in 1915 by Dr. Joseph DeLee, author of the most important obstetric textbook of the era. Dr. Lee's vision of childbirth as a destructive pathology rather than a normal, natural function rendered the midwife archaic, a fact he happily acknowledged. In the premier issue of the *American Journal of Obstetrics and Gynecology*, Dr. DeLee proposed a sequence of interventions designed to save women from the "evils natural to labor." The interventions included routine use of sedatives, ether, episiotomies, and forceps.

> DeLee was a very influential obstetrician who served as head of obstetrics at Northwestern University and chairman of obstetrics and gynecology at the University of Chicago. He changed the focus of health care during labor and delivery from responding to problems as they arose to preventing problems through routine use of interventions to control the course of labor. This change led to medical interventions being applied not just to the relatively small number of women who had a diagnosed problem, but instead to every woman in labor.
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> American obstetrics is still functioning under the medical paradigm of childbirth it inherited from Dr. DeLee. Other wealthy, industrialized countries have national health services, in which elements of care that aren't needed and don't bring improved health tend to be dropped because of the cost. In the U.S. health-care industry, the more care that is provided, frequently more money is made by the doctors and the hospitals, so there is less incentive to not use these methods.[30]

By 1935, midwife attendance had dropped to less than fifteen percent of all births, as compared to approximately half of all births in 1900. By the 1930s, midwives mostly served black or poor-white manual laborers in the rural south. The increase in physician attendance of

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[29] Davis-Floyd, R., *Mainstreaming Midwives: The Politics of Change*, Routledge, New York 2006, pp. 32-33.
[30] Rooks, Judith, *Our Bodies, Ourselves* (2005), in particular Chapter 22, "The History of Childbearing Choices in the United States," reprinted at http://www.ourbodiesourselves.org/book/companion.asp?id=22&compID=75 (last updated December, 2006).

birth to some eighty-five percent, was accompanied by a forty-one percent *increase* in infant mortality due to birth injuries between 1915 and 1929, attributed to obstetrical interference in birth.[31]

Even as American midwifery was sliding rapidly into decline due to a multitude of pressures, nurses began a resuscitation of non-physician professionalism in American birthing. A form of practice known as nurse-midwifery evolved in the rural south, particularly with the Frontier Nursing Service (FNS) founded in 1925 by Mary Breckinridge, formerly a public health nurse for the Red Cross in France at the end of World War I. Ms. Breckinridge brought back from overseas knowledge and skills she acquired from British nurse-midwives.

Though commencing in rural Kentucky, Ms. Breckinridge actively exported her vision of care elsewhere, for example to New York City, where she helped found the Lobenstine Clinic (1930) and Lobenstine Midwifery School (1931), to formalize and professionalize nurse-midwifery training.[32]

In the mid-1950s obstetric leaders of several inner-city teaching hospitals recognized the potential value of nurse-midwifery in dealing with the post-war baby boom, thus transferring the situs of most nurse-midwifery care from the home to the hospital, and under the supervision of physicians. Nurse-midwives were influential, in part because they won the respect of the physician community through a required educational process sufficiently similar to the medical-school model for doctors to recognize and feel comfortable with. Yale University School of

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[31] Many sources document this trend. *See generally* Rooks, Judith, *Our Bodies, Ourselves* (2005), in particular Chapter 22, "The History of Childbearing Choices in the United States," reprinted at http://www.ourbodiesourselves.org/book/companion.asp?id=22&compID=75 (last updated December, 2006). This apparent dichotomy is echoed in present-day America, when some ninety-five percent of births are physician attended, yet the U.S. experiences one of the highest rates of maternal and infant mortality and morbility in the industrialized world. *See, e.g.*, McCarthy, M., "US Maternal Death Rates Are on the Rise," *Lancet* 348 (1996): 394; Wagner, M., *Born In the USA: How A Broken Maternity System Must Be Fixed To Put Women And Children First* (University of California Press, Berkeley 2006).

[32] *See, e.g.*, Rooks, J., *Midwifery and Childbirth in America*, Temple University Press, Philadelphia (1997).

Nursing was a leader in the field, benefiting from the contributions of many distinguished and precedent-setting midwives. These included Helen Varney-Burst, who not only advanced the practice of nurse-midwifery and helped professionalize and standardize the educational requirements, but also served as a chronicler of the profession itself.[33]

Due in significant part to the increasing "medicalization" of birth with the modernization of obstetrics as a lucrative medical specialty for physicians, many new labor and delivery practices developed. "In the 1950s, women were expected to be passive in child birth. Birth took place in a cold medicalized surrounding and the mothers were often denied information, restrained while in labor, and sometimes drugged and strapped. To fit the schedules of doctors, births were often induced when not necessary; other times they were delayed by holding patients' legs together."[34]

Coinciding time-wise with these birthing practices, the resuscitation of American midwifery in the nursing/hospital context provided a challenging setting in which the contributions of nurse-midwives were especially valuable to mothers – now viewed as "patients." Nurse-midwives were important innovators and "humanizers" in American obstetrics units. They re-introduced the concept of family-centered maternity care (such as allowing fathers in the delivery room and retaining the baby in the mother's room, rather than segregating it in a nursery with other babies), promoted childbirth education, and encouraged mothers to breastfeed in an age of formula and sterilized bottles.

Even with the advent of nurse-midwifery, however, birthing issues did not end in the 1950s. The physician sub-culture of condescension toward women as passive recipients of forced

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[33] *See, e.g.*, Varney Burst, H. and Thompson, J.E., "Genealogic Origins Of Nurse-Midwives And Its Antecedents," *Journal of Midwifery and Women's Health*, 48(6): 464-470.

[34] Rodwin, M., "Patient Accountability and Quality of Care: Lessons From Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements," 20 Am. J. L. and Med. 147, 158 (1994).

wisdom proved remarkably persistent. According to a 1979 medical textbook on obstetrics and gynecology: "The evaluation of the patient's personality need not be a lengthy matter. … Character traits are expressed in her walk, her dress, her makeup ... The observant physician can quickly make a judgment as to whether she is overcomplaining, overdemanding, aggressive, passive, erotic or infantile …."[35]

The general (albeit not universal) limitation of certified nurse-midwives to the obstetric departments of hospitals left in limbo those women who wished to resist the routine use of medical interventions faced in hospitals, with the attendant risks.[36] This gap was gradually filled by non-nurse midwives – the so-called "direct-entry midwives" who provided pre-natal, labor and delivery care outside of hospitals, either in free-standing birth centers or at home births, typically without supervision by ob-gyns or other physicians. The lay-midwifery/home-birth movement developed during the 1960s and 1970s as part of "a grassroots effort by women to reclaim power over their own bodies and births."[37] It involved primarily a small number of well-educated, middle-class, white women opting for home births, as well as even smaller numbers of limited populations of women with specific religious or sub-cultural reasons for selecting home-delivery, such as Mormons, certain Native American groups, and so on.

In 2003 direct-entry midwives attended four of every thousand U.S. births and almost five of every thousand vaginal births (non-cesarean). Today, the majority of women who choose home birth are professional, white, and middle class, along with a significant minority of poor

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[35] J. Robert Willson et al., Obstetrics and Gynecology 51 (6th ed. 1979).

[36] For this summary of child-bearing in the U.S., the author is indebted to Rooks, Judith, *Our Bodies, Ourselves* (2005), in particular Chapter 22, "The History of Childbearing Choices in the United States," reprinted at http://www.ourbodiesourselves.org/book/companion.asp?id=22&compID=75 (last updated December, 2006). *See also* Marsden, W., M.D., *Born In the USA: How A Broken Maternity System Must Be Fixed To Put Women And Children First* (University of California Press, Berkeley, 2006), especially Chapter 4: "Hunting Witches: Midwifery In America," pp. 99-125.

and working-class women who consistently choose home birth.[38] Even so, the vast majority of women in the United States give birth in hospitals, attended by obstetrician-gynecologists (ob-gyns): that is, by *surgeons*, whose training necessarily encompasses surgery as a standard weapon in the arsenal against the "pathology" of birth.[39]

Many people assume that doctor-provided care is safer than that provided by other practitioners. In reality, the U.S. consistently displays one of the highest medical-error rates in the industrialized world. For example, a recent study showed the U.S. with the highest error rate among six industrialized nations studied, ranking higher than Canada, Australia, New Zealand, Germany and the United Kingdom, as surveyed by the Commonwealth Fund.[40]

Though nearly all American women deliver their babies in hospitals, with surgeon-physicians in attendance, twenty-eight countries have a lower maternal mortality rate, and for more than twenty-five years, the number of American women dying around the time of childbirth has been increasing – one thousand a year, half of which are believed to have been preventable.[41] If this reality is merely a reflection of the informed choice of individuals, no human-rights issue is presented, even if medically-guided births are no safer than others. On the other hand, if women choose physician-attended hospital births at such unusually great rates due to misinformation about the clinical situation and options, and undue restriction of alternative services, their rights are violated and a remedy is necessary.

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[37] Rooks, Judith, *Our Bodies, Ourselves* (2005), in particular Chapter 22, "The History of Childbearing Choices in the United States," reprinted at http://www.ourbodiesourselves.org/book/companion.asp?id=22&compID=75 (last updated December, 2006).

[38] *E.g.*, Davis-Floyd, R., et al., *Mainstreaming Midwives: The Politics of Change* (Routledge New York 2006), p. 22, n. 4.

[39] *See, e.g.*, Lipscomb, G., "Senior obstetric-gynecologic residents' perceptions of their surgical training, experiences and skill," *J Reprod Med.* 1993 Nov;38(11):871-4 (discussing senior obstetric and gynecologic residents' self-perceptions of surgical skill and arguing a need for comprehensive reevaluation of the components of gynecologic surgical curricula).

[40] Published at www.healthaffairs.org.

Birth Issue: Surgical Delivery

The surgical removal of a baby from the womb of its mother is an act that exudes deep philosophical and cultural conflict.[42]

Although the matter is not entirely without dispute, it is generally believed that an edict of the Caesars of Imperial Rome (*Lex Caesarea*) gave rise to the term "cesarean section." This ancient law provided that any pregnant woman dying at or near term was to be delivered by C-section, that is, the surgical delivery of a fetus. Mothers expected to survive the delivery were not, however, to be sacrificed for the welfare of the fetus.[43] Thus, the legal origins of modern cesarean section are rooted in surgical removal of a fetus from a *dying* mother only.[44]

Ironically, in twentieth-century America where increasingly sophisticated medical technology was within grasp of the surgeons who came to dominate maternity care, this surgical procedure came to be used – and aggressively promoted – in regard to healthy mothers. C-section was transformed from an effort to salvage a living infant from a dying mother, to routine surgical removal of a fetus from a woman with a future.

A cesarean section constitutes major surgery.[45] Overall, that is, without differentiation for high-risk individuals, it is two to twelve times more likely to result in maternal death than vaginal delivery.[46] The doctor – a surgeon -- administers an anesthetic, drains the woman's bladder, scrubs her skin, opens the abdomen using a low "bikini" incision, peels the bladder

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[41] *E.g.*, Wagner, M., *Born In the USA: How A Broken Maternity System Must Be Fixe To Put Women And Children First*, University of California Press, Berkeley, 2006, p. 9. Dr. Wagner also notes that forty-one countries have lower infant-mortality rates than the U.S. *Id.*

[42] Myers, M., "ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?" 49 S.D. L. REV. 526, 535 (2003).

[43] *E.g.*, The Facts on File Encyclopedia of Word and Phrase Origins , discussed at http://alt-usage-english.org/excerpts/fxcaesar.html. *See also* Sachs, B., "Vaginal Birth After Cesarean: A Health Policy Perspective," *Clinical Obstetrics & Gynecology* 44(3):553-560 (September 2001).

[44] CHRISTOPHER NORWOOD, HOW TO AVOID A CESAREAN SECTION 21 (1984).

[45] BRUCE L. FLAMM, BIRTH AFTER CESAREAN: THE MEDICAL FACTS 17 (1990).

away from the uterus, cuts through the uterine wall, and removes the fetus. The surgeon typically hands off the baby immediately to another physician or advanced-training nurse to care for, then removes the placenta, sews the bladder back into place, and closes the "bikini" incision with six or seven layers of stitching.[47]

Most women spend an average of four days in the hospital recovering from the surgery.[48] Many women feel weakened from the impact of the anesthesia and surgical stress for weeks or months after they go home.[49] In addition, half of these women experience depression, discomfort, and infections.[50]

Cesarean section is the second most prevalent surgical procedure in the United States, at just over one million in 2002.[51] The U.S. has an unacceptably high c-section rate, and an official health policy is in place to reduce this rate.[52]

In 1979 the National Institute of Child Health and Human Development held a Consensus Development Conference on Cesarean Childbirth to analyze the then record-high American cesarean birth rate of 15%. The report issued two years later, lamenting the 15% rate and calling for a reduction. Notwithstanding the clarion call, the rate actually rose to approximately 25%, highest by far of any industrialized country. Some ten years later, nearly half of American c-

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[46] *See, e.g.*, Lorna McBarnette, Women and Poverty: The Effects on Reproductive Status, 12 WOMEN & HEALTH 55, 72 (1988).
[47] CHRISTOPHER NORWOOD, HOW TO AVOID A CESAREAN SECTION 21 (1984).
[48] PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, UNNECESSARY CESAREAN SECTIONS: HALTING A NATIONAL EPIDEMIC 2, p. 38 (1992).
[49] CHRISTOPHER NORWOOD, HOW TO AVOID A CESAREAN SECTION 21 (1984).
[50] CHRISTOPHER NORWOOD, HOW TO AVOID A CESAREAN SECTION 21-23 (1984).
[51] National Center for Health Statistics, Births-Method of Delivery, available at http://www.cdc.gov/nchs/fastats/delivery.htm. There were a reported 2,958,423 vaginal deliveries, 634,426 primary cesareans, 409,420 repeat cesareans, for a national cesarean delivery rate of 26.1 percent. *Id.*
[52] *See, e.g.*, US Department of Health and Human Services, Public Health Service. *Healthy People 2000*. DHHS Publication No. 91-50213. Washington, DC: US Government Printing Office: 1991:378-379 (establishing c-section goal of 15%); *Cesarean Childbirth*. Report of a Consensus Development Conference. NIH Publication No 82-2067; Bethesda, MD: Department of Health and Human Services; 1981 (Consensus Development Conference on Cesarean Childbirth of the National Institute of Child Health and Human Development convened in 1979 to sound

sections were found to be medically unnecessary: in 1990, out of the 982,000 cesareans performed in the United States, 480,520 procedures were found unnecessary.[53] Thus the problem of a persistent excessive number of c-sections was compounded by the needlessness of half of them.

Questions have also arisen as to a possible link between the c-section rate, including of forced c-sections, and the economic and racial characteristics of the recipients. A national study found that eighty percent of the patients who received court-ordered cesarean sections were African-American, African, Asian, and Latina.[54] Nearly half of court-ordered c-sections, transfusions and hospital detentions for pregnant women were directed against African-American women.[55] Half of the women were unmarried, and over one-fourth did not speak English as their primary language.[56] The same study revealed that forty-six percent of the directors of fellowship programs in maternal and fetal medicine believed that mothers who refused medical advice when their fetuses were "in danger" required detention in hospitals or other facilities until compliance with the advice could be obtained. In a particularly telling and chilling response, approximately one-quarter of them supported state surveillance of women in the third trimester of pregnancy; and, further:

> Court orders have been obtained for cesarean sections in 11 states, for hospital detentions in 2 states, and for intrauterine transfusions in 1 state. Among 21 cases in which court orders were sought, the orders were obtained in 86 percent; in 88 percent of those cases,

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alarm over then record high American cesarean birth rate of 15%, which later rose to approximately 25%, highest by far of any industrialized country).

[53] PUBLIC CITIZEN'S HEALTH RESEARCH GROUP, UNNECESSARY CESAREAN SECTIONS: HALTING A NATIONAL EPIDEMIC 2, 40 (1992). *See also* Bates, K., "CESAREAN SECTION EPIDEMIC: DEFINING THE PROBLEM--APPROACHING SOLUTIONS", 4 B.U. Pub. Int. L.J. 389, 390, n. 16 (1995).

[54] Veronika E.B. Kolder et al., Court-Ordered Obstetrical Interventions, 316 NEW ENG. J. MED. 1192, 1193 (1987).

[55] Veronika E.B. Kolder et al., Court-Ordered Obstetrical Interventions, 316 NEW ENG. J. MED. 1192 (1987). This figure does not include African women, who were counted along with Asians as representing 33% of those receiving forced cesareans.

[56] Veronika E.B. Kolder et al., Court-Ordered Obstetrical Interventions, 316 NEW ENG. J. MED. Volume 316:1192-1196, No. 19 (May 7, 1987), abstract reprinted at http://content.nejm.org/cgi/content/abstract/316/19/1192.

> the orders were received within six hours. … All the women were treated in a teaching-hospital clinic or were receiving public assistance. No important maternal morbidity or mortality was reported. Forty-six percent of the heads of fellowship programs in maternal-fetal medicine thought that women who refused medical advice and thereby endangered the life of the fetus should be detained. Forty-seven percent supported court orders for procedures such as intrauterine transfusions. We conclude from these data that court-ordered obstetrical procedures represent an important and growing problem that evokes sharply divided responses from faculty members in obstetrics. Such procedures are based on dubious legal grounds, and they may have far-reaching implications for obstetrical practice and maternal and infant health.[57]

The U.S. cesarean rate increased from 5.5 percent in 1970 to 26.1 percent in 2002, the highest rate ever reported.[58] The World Health Organization says there is no justification for any region in the world to have a cesarean rate more than ten to fifteen percent. At the same time the U.S. variously ranks between twenty-first and twenty-eighth in the world for maternal mortality, a death rate that has not decreased since 1982, and increased in 1999.[59] The U.S. Center for Disease Control estimates that maternal deaths may be under-reported by one half to two thirds and that half of U.S. maternal deaths are preventable.[60]

American research consistently suggests that reduction of c-section rates is resistant to change efforts, and is more a process of changing physician behavior than of medical education or clinical need.[61] Doctors perform unneeded and unwanted cesarean sections.[62] Overall, without

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[57] Veronika E.B. Kolder et al., Court-Ordered Obstetrical Interventions, 316 NEW ENG. J. MED. 1192, 1193-94 (1987).
[58] Citizens for Midwifery, "Cesarean Rate Rises to Highest Ever Reported in the United States," *Fact Sheet* (2002), at http://www.cfmidwifery.org/.
[59] *See generally* Ina May Gaskin, Ina May's Guide to Childbirth, Bantam 274-77 (2003).
[60] *See generally* Ina May Gaskin, Ina May's Guide to Childbirth, Bantam 274-77 (2003).
[61] *E.g.*, Main, E., "Reducing Cesarean Birth Rates With Data-driven Quality Improvement Activities," 103 *Pediatrics* 1, pp. 374-83, at p. (1999);
[62] Pamela S. Eakins, The American Way of Birth (1986); Beatrice S. Levin, Women and Medicine 162 (1980); Judith W. Leavitt, Brought to Bed: Childbearing in America: 1750 to 1950 65 (1986); Ingrid Van Tuinen & Sidney M. Wolfe, Unnecessary Cesarian Sections: Halting a National Epidemic (1992); Noralou P. Roos, Hysterectomy: Variations in Rates Across Small Areas and Across Physicians' Practices, 74 Am. J. Pub. Health 327 (1984); Carol Sakala, Medically Unnecessary Cesarean Births: Introduction to a Symposium, 37 Soc. Sci. & Med. 1177 (1993) [hereinafter Sakala, Medically Unnecessary Cesarean Births]; Carol Sakala, **Midwifery** Care and Out-of-Hospital Birth Settings: How Do They Reduce Unnecessary Cesarean Section Births?, 37 Soc. Sci. & Med. 1233 (1993) [hereinafter Sakala, **Midwifery** Care]; Centers for Disease Control, Rates of Cesarian Delivery - United States, 42 Morbidity & Mortality Wkly. Rep. 286 (1991); Too Many Cesarians, Consumer Reps., Feb. 1991, at 120.

differentiation for specific high-risk populations, cesarean births usually present greater risk than vaginal births for women, cost more and often leave women far less satisfied.[63] Subjective factors such as cultural ideology and fetal protectionist beliefs may influence doctors to perform forced cesarean sections. For instance, some doctors express hostility towards women who refuse a cesarean section based on cultural or religious values.[64] Some doctors view these women as irresponsible, irrational, callous, or insufficiently caring of their children.[65]

In one case, for example, doctors forcibly restrained a Nigerian woman to her hospital bed because she opposed a cesarean section, removed her husband from the delivery room, bound her ankles and wrists in leather cuffs, and performed the forced surgery on her.[66] In another case, doctors characterized a Bedouin woman, who rejected the procedure because she feared she would die if operated on, as ignorant and incapable of arriving at an intelligent decision.[67]

"The complex problem of physicians performing forced and unnecessary cesarean sections on pregnant women has generated national concern."[68] Earlier case law gave short shrift to the rights of the parents to refuse surgical intervention, even on religious grounds. From 1981 to 1986, fifteen court orders were sought in the United States to authorize cesarean sections against women who refused them, of which thirteen were granted.[69] In several cases where

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[63] *E.g.*, Cynthia S. Mutryn, Psychosocial Impact of Cesarean Section on the Family: A Literature Review, 37 Soc. Sci. & Med. 1271 (1993); E.L. Shearer, Cesarean Section: Medical Benefits and Costs, 37 Soc. Sci. & Med. 1223 (1993)).

[64] *See, e.g.*, Deborah J. Krauss, "Regulating Women's Bodies: The Adverse Effect of Fetal Rights Theory on Childbirth Decisions and Women of Color," 26 HARV. C.R.-C.L. L. REV. 523, 532 (1991).

[65] NANCY W. COHEN & LOIS J. ESTNER, SILENT KNIFE 50, p. 13 (1983).

[66] Janet Gallagher, "Prenatal Invasions & Interventions: What's Wrong With Fetal Rights," 10 HARV. WOMEN'S L.J. 9, 9-10 (1987).

[67] Deborah J. Krauss, "Regulating Women's Bodies: The Adverse Effect of Fetal Rights Theory on Childbirth Decisions and Women of Color," 26 HARV. C.R.-C.L. L. REV. 523, 532 (1991).

[68] Bates, K., "CESAREAN SECTION EPIDEMIC: DEFINING THE PROBLEM--APPROACHING SOLUTIONS", 4 B.U. Pub. Int. L.J. 389, 390 (1995).

[69] Michael Phillips, Maternal Rights v. Fetal Rights: Court-Ordered Cesareans, 56 MO. L. REV. 411 (1991).

pregnant women have refused surgery in violation of a court order, the women have delivered healthy babies through natural childbirth.[70]

The terse 1981 opinion from Georgia, *Jefferson v. Griffin Spalding County Hospital Authority,* illustrates the problem.[71] Mr. and Mrs. Jefferson opposed the surgical delivery of their unborn child on religious grounds, but their wishes were over-ridden by orders of the Superior and Juvenile Courts in Butts County, which authorized plaintiff hospital to perform a cesarean section upon the mother for the delivery of the unborn child, and awarded temporary custody of the unborn child to the State Department of Human Resources. A hospital physician had allegedly found that the mother had a condition in her pregnancy, a complete placenta previa, such that the unborn child would not survive a vaginal delivery, but the child would almost certainly live if delivered by caesarean section prior to the beginning of labor. The fetus was viable and fully capable of sustaining life independent of the mother. The trial courts awarded the State temporary custody of the unborn child and ordered the mother to submit to the cesarean section.

This startling issue only rarely percolates to the surface of the law. Many forced c-sections go unreported. According to one scholar: "The problem of coerced cesarean sections has not received the public attention and social commentary it deserves because of the lack of written decisions."[72]

In the 1990s, the judicial temperament seems slowly to have cooled toward tying pregnant women down and cutting them open. For example, the State of Illinois attempted to

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[70] *See, e.g., Doe v. Doe, infra; Jefferson, infra.* Physician predictions of fetal harm are often incorrect. *Id. See also* George J. Annas, Forced Cesareans: The Most Unkindest Cut of All, HASTINGS CENTER REPORT, June 1982, at 17.

[71] 247 Ga. 86; 274 S.E.2d 457; 1981 Ga. LEXIS 613 (1981).

[72] Bates, K., "CESAREAN SECTION EPIDEMIC: DEFINING THE PROBLEM--APPROACHING SOLUTIONS", 4 B.U. Pub. Int. L.J. 389, 400, n. 95 (1995).

override a pregnant woman's decision to refuse a cesarean section. A lawyer for the hospital claimed that without the surgery, the baby would "almost assuredly . . . be born dead or brain damaged." The trial court ruled that the state could not force the woman to submit to a cesarean, and the Illinois Appellate Court unanimously affirmed. [73] (Not long after the court's decision, the woman delivered a healthy baby boy through natural childbirth.) The Illinois decision is overtly pedagogical, and merits quoting at some length:

> Both the State and the Public Guardian argued that the circuit court should have balanced the rights of the unborn but viable fetus which was nearly at full term and which, if the uncontradicted expert testimony of the physicians had been accurate, would have been born dead or severely retarded if Doe delivered vaginally, against the right of the competent woman to choose the type of medical care she deemed appropriate, based in part on personal religious considerations. We hold today that Illinois courts should not engage in such a balancing, and that a woman's competent choice in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus.
>
> It cannot be doubted that a competent person has the right to refuse medical treatment. The Illinois Supreme Court summed up American attitude and law on this issue very well in *In re Estate of Longeway*: "No right is more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of [the individual's] own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." [Citation omitted.] Thus, "every human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body; and a surgeon who performs an operation without his [or her] patient's consent commits an assault for which he [or she] is liable in damages." [Citation omitted.]
>
> In Illinois the common law protects the right of a competent individual to refuse medical treatment. …
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> The United States Supreme Court, in *Cruzan v. Director, Missouri Department of Health* (1990), 497 U.S. 261, 111 L. Ed. 2d 224, 110 S. Ct. 2841, 2851, held that the due process clause of the 14th amendment confers a significant liberty interest in avoiding unwanted medical procedures. Concurring with the majority opinion, Justice O'Connor stated that the liberty guaranteed by the due process clause must protect, if it protects anything, an individual's "deeply personal" decision to reject medical treatment. "Because our notions of liberty are inextricably entwined with our idea of physical freedom and self determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause." [Citation omitted.]

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[73] *Doe v. Doe*, 260 Ill. App. 3d 392 (1994), *cert.denied* 510 U.S. 1168, 114 S. Ct. 1198, 127 L. Ed. 2d 547, 1994 U.S. LEXIS 1988, 62 U.S.L.W. 3574 (1994). *See also* Don Terry, "Legal Fight Over Caesarean Pits Mother Against Fetus," N.Y. TIMES, Dec. 14, 1993, at A22.

> The Illinois Supreme Court has acknowledged that the state right of privacy protects substantive fundamental rights, such as the right to reproductive autonomy. [Citation omitted.] Further, the court has conceptually linked the right to privacy with the right of bodily integrity. … In *Stallman v. Youngquist* (1988), 125 Ill. 2d 267, 275, 531 N.E.2d 355, 360, 126 Ill. Dec. 60, the supreme court refused to recognize a tort action against a mother for unintentional infliction of prenatal injuries because it would subject the woman's every act while pregnant to state scrutiny, thereby intruding upon her rights to privacy and bodily integrity, and her right to control her own life. …
>
> Particularly important to our supreme court's holding in Stallman was the recognition that the relationship between a pregnant woman and a fetus is unique, and "unlike the relationship between any other plaintiff and defendant. No other plaintiff depends exclusively on any other defendant for everything necessary for life itself. No other defendant must go through biological changes of the most profound type, possibly at the risk of her own life, in order to bring forth an adversary into the world. It is, after all, the whole life of the pregnant woman which impacts upon the development of the fetus. * * * It is the mother's every waking and sleeping moment which, for better or worse, shapes the prenatal environment which forms the world for the developing fetus. That this is so is not a pregnant woman's fault; it is a fact of life." …
>
> Applied in the context of compelled medical treatment of pregnant women, the rationale of Stallman directs that a woman's right to refuse invasive medical treatment, derived from her rights to privacy, bodily integrity, and religious liberty, ***is not diminished during pregnancy***. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant. The potential impact upon the fetus is not legally relevant; to the contrary, the Stallman court explicitly rejected the view that the woman's rights can be subordinated to fetal rights. … A woman is under no duty to guarantee the mental and physical health of her child at birth, and thus cannot be compelled to do or not do anything merely for the benefit of her unborn Child.[74]

The United States Supreme Court was given the opportunity to review (and therefore reverse) the Illinois ruling, but declined to do so, leaving the parental win intact.[75]

Similarly, in the case of *In re A.C.*, discussed earlier, a physician at George Washington University Hospital in the District of Columbia decreed to Angela Carder, a dying cancer patient, that if she did not have a cesarean section, her health and her baby's life would be seriously endangered. The hospital sought a declaratory order from the Superior Court to determine whether it should proceed with the procedure to save the life of the fetus. After a three hour

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[74] *Doe v. Doe*, 260 Ill. App. 3d 392, 400-402 (1994).

[75] *Doe v. Doe*, 510 U.S. 1168, 114 S. Ct. 1198, 127 L. Ed. 2d 547, 1994 U.S. LEXIS 1988, 62 U.S.L.W. 3574 (1994) (denying petition for certiorari).

hearing in Carder's hospital room, the trial court ordered the performance of a cesarean section. Carder refused. The doctor performed the surgery over his patient's objection. Mrs. Carder and her baby died shortly after the procedure. The appellate court then granted a petition for a rehearing, vacated the trial court's order and held that a physician should defer to a competent pregnant woman's decision to accept or reject a cesarean section operation.[76] The court noted with great emphasis that "it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a caesarean section." The case was not appealed to the U.S. Supreme Court.

One year after *In re A.C.*, the Supreme Court determined in a non-c-section case that the Fourteenth Amendment stood for the principle that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment."[77] It also was given but declined the opportunity to review the ground-breaking opinion of the Illinois Supreme Court in the *Baby Boy Doe* case (holding that a woman's right to refuse treatment was not diminished by pregnancy).[78] Over the next decade, however, the social climate again cooled toward the rights of pregnant women, and America's conflicted attitude toward c-sections persisted into the new millenium.

In 2004, some ten years after Baby Doe was delivered vaginally (and healthy), the State of Utah charged Melissa Rowland with the murder of her stillborn fetus. Utah claimed that the death resulted from Ms. Rowland's rejection of the advice of her physicians to deliver her twins surgically.[79] According to commentators at New York's National Advocates for Pregnant Women, "the approach taken by the State raises important and troubling issues regarding the

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[76] *In re A.C.*, 573 A.2d 1235 (D.C. 1990).
[77] *Cruzan v. Director, Missouri Dept. of Health* , 497 U.S. 261, 278 (1990).
[78] 510 U.S. 1168, 114 S. Ct. 1198, 127 L. Ed. 2d 547, 1994 U.S. LEXIS 1988, 62 U.S.L.W. 3574 (1994).
[79] Ms. Rowland ultimately avoided the homicide charge by pleading guilty to lesser child endangerment charges.

autonomy rights of pregnant women, as well as their right to speak on behalf their unborn children. … We conclude that if Ms. Rowland is to be judged legally culpable for the death of her fetus, then the courts must first create a new and significant exception to the doctrine of informed consent and the common law and constitutional principles upon which it is based. Such a precedent could introduce a substantial disparity between the rights of pregnant women and those of all other persons."[80]

At the other end of the spectrum, the *National Review* published a remarkably mean-spirited commentary making light of Ms. Rowland's plight. In a piece by one Virginia Graham entitled "Give Me a "C"! Bed rest, doting nurses, epidurals...what's not to like?", Ms. Graham opined about the overweight, mentally-ill Ms. Rowland:

> We can only speculate as to what Melissa Ann Rowland was thinking when she said — allegedly, of course — that having a Caesarean section to save the lives of her twins would "ruin her life." Was she about to embark on a new career as a Penthouse pet? Model swimsuits for Sports Illustrated? … Rowland is now disputing the prevailing story that she initially refused a C-section because of "cosmetic motivations." Given that she reportedly weighs 350 pounds, maybe she's telling the truth. … Now, no one wants to see a woman who just gave birth sitting in jail when she should be home nursing the surviving infant — assuming, of course, that breastfeeding wouldn't ruin her life. …
>
> She appears to be the kind of reckless reproducer that makes otherwise reasonable people yearn — just for a minute — for a Homeland Bureau of Pregnancy Licensing. … But let's assume, just for the heck of it, that Rowland wasn't just concerned about how fetching her naked body would look to future suitors. What if she really did fear surgery? Even with the C-section rate exceeding 25 percent nationwide, driven upward in part by women who would rather not labor, the worry warts insist on calling it "Major Surgery," and sure, there are some risks. But as Major Surgery goes, a C-section — without complications, and with a good insurer — is a pretty good deal. …
>
> Maybe Melissa Rowland really was terrified at the prospect of surgery, and her doctors failed her by not adequately addressing those fears. Does fear, born of ignorance, make her less culpable for her baby's death?[81]

Ms. Graham's caustic humor at the expense of women undergoing major surgery they don't want is hardly original. In a telling display of what many of the surgeons themselves find

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[80] Minkoff, H., *et al.*, "Melissa Rowland and the Rights of Pregnant Women," *Obstetrics & Gynecology* 2004;104:1234-1236.

funny, the humor magazine *Journal Of Irreproducible Results* – which solicits articles that "appeal to scientists, doctors, and engineers"[82] – published a bogus research study summary entitled "The Reciprocal Natural Childbirth Index." The Index, posted in at least one Ivy League medical school,[83] added "points" to a woman's childbirth-services score if: she or another person check her cervix prior to arrival at the hospital; she or her husband has a hyphenated last name; she has more than four years of college; she has a written birth plan; she is insured by a managed health care plan; and other rollicking factors. Concludes the author:

> We have found that a Reciprocal Natural Childbirth Index score of 30 or greater should earn the woman in labor immediate consideration for cesarean section. In fact, since you can get a score of 30 without even being in labor, someone with a high enough score could be offered a C-section at her convenience during regular working hours.[84]

Ms. Rowland is not alone in being deemed a criminal for her maternity conduct. Certain states in the U.S. have, in recent years, pursued increasingly aggressive prosecution of pregnant women who are deemed to have failed at pre-natal care. A prime example is South Carolina, whose Supreme Court has applied to fetal health a state statute punishing child abuse, upholding a murder conviction arising from a stillbirth to a mother who had taken cocaine during her pregnancy. The State court observed in 2003:

> The drug "cocaine" has torn at the very fabric of our nation. Families have been ripped apart, minds have been ruined, and lives have been lost. It is common knowledge that the drug is highly addictive and potentially fatal. The addictive nature of the drug, combined with its expense, has caused our prisons to swell with those who have been motivated to support their drug habit through criminal acts. In some areas of the world, entire governments have been undermined by the cocaine industry.[85]

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[81] March 16, 2004, http://www.nationalreview.com/jgraham/graham200403160901.asp.
[82] *Journal Of Irreproducible Results* homepage, http://www.jir.com/home.html.
[83] See discussion at Wagner, M., *Born In the USA: How A Broken Maternity System Must Be Fixe To Put Women And Children First*, University of California Press, Berkeley, 2006, p. 19.
[84] Berg., A., "The Reciprocal Natural Childbirth Index," *Journal of Irreproducible Results* 36, No. 2 (March/April 1991): 27.
[85] *State v. McKnight*, 352 S.C. 635, 576 S.E.2d 168, 2003 S.C. LEXIS 23 (2003), *cert. denied* 540 U.S. 819; 124 S. Ct. 101; 157 L. Ed. 2d 36; 2003 U.S. LEXIS 5604; 72 U.S.L.W. 3235 (2003).

The jury was unable to return a verdict, so the prosecution re-brought the action and, on round two, won a conviction. South Carolina is the only state where the courts have included viable fetuses within the scope of child abuse laws in an attempt to prosecute pregnant women. The U.S. Supreme Court declined to review the matter.

Meanwhile, the American College Of Obstetricians and Gynecologists ("ACOG") continues to ask: "Should Refusal to Undergo a Cesarean Delivery Be a Criminal Offense?"[86]

ACOG And VBAC

The organization that claims to be the "nation's leading authority on women's health for more than 50 years" is the American College of Obstetricians and Gynecologists. ACOG boasts a membership that includes more than 90% of all American board-certified ob-gyns, and is the self-described "voice of women's health".[87] It sets the standards for obstetrical practice in this country, in large part because of its members' belief that "failure to comply with the ACOG recommendations will increase medical legal risks should a poor outcome be experienced."[88] Its members testify before U.S. Congress committees on the formulation of public policy.[89] Its practice standards govern not only dispensation of services to women, but also whether the service will be covered by health insurance, with insurance companies routinely monitoring changes in ACOG policies to adjust their coverage accordingly.[90]

Membership is limited to obstetrician-gynecologists. It is, in fact, a trade association:

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[86] EDITORIALS: Richard L. Berkowitz, Should Refusal to Undergo a Cesarean Delivery Be a Criminal Offense? Obstet. Gynecol., Dec 2004; 104: 1220 - 1221.
[87] ACOG News Release, May 9, 2007, published at http://www.acog.org/from_home/publications/press_releases/nr05-09-07-1.cfm.
[88] D'Angelo, R., Comment On "Neonatal Morbidity Associated with Uterine Rupture: What Are the Risk Factors?", by Bujold E., *American Journal of Obstetrics and Gynecology* 2002; 186:311-4, Comment published at *Obstetric Anesthesia Digest* September 2002:132.
[89] E.g., testimony of Dr. Shelby Wilbourne, U.S. Senate Committee on the Judiciary, February 11, 2003, published at http://judiciary.senate.gov/testimony.cfm?id=600&wit_id=1595.
[90] *See, e.g.*, Premier AEIX Risk E-lert Newsletter, ACOG updates labor and delivery best practices," January 13, 2006, published at htt;://www.premierinc.com/risk/education-newsletters/risk-e-lert/2006/January06.jsp; Aetna,

> ACOG is not a college in the sense of an institution of higher learning, nor is it a scientific body. It is a "professional organization" that in reality is one kind of trade union. Like every trade union, ACOG has two goals: promote the interests of its members, and promote a better product (in this case, well-being of women).[91]

One-third of all cesareans are performed on women who have had at least one cesarean in the past.[92] This reflects the traditional American physician's wisdom, "once a cesarean, always a cesarean."[93] Yet there are many women who, having delivered surgically in the past, wish to deliver vaginally. These women are designated as "VBACs" – vaginal birth after cesarean.

Many hospitals mandate that any pregnant patient who has previously undergone uterine surgery (including a c-section) *must* deliver surgically if the delivery is to take place on hospital premises. Dr. Marsden Wagner, M.D., a perinatal epidemiologist and former Director of the European Regional Office of the Women and Children's Health for the World Health Organization, has called this trend in American hospitals a "widespread failure to honor the rights of pregnant and birthing women".[94]

For purposes of the instant paper, the question is not whether VBAC is desirable from a medical point of view. Analysis of the merits of any given *medical* decision to assist or deny VBAC is beyond the scope of this paper. The focus of this work is identification and analysis of *non-medical* motivations in the formulation of clinical recommendations for or against surgical intervention in the birth process, specifically, cesarean section for a woman who has previously delivered surgically but wishes to deliver vaginally from a subsequent pregnancy.

"Clinical Policy Bulletin: Home Births"," Policy No. 0329, Review Date June 26, 2007, published at http://www/aetna.com/cpb/medical/data/300_399/0329.html.

[91] Wagner, M., "What Every Midwife Should Know About ACOG and VBAC: Critique of ACOG Practice Bulletin No. 5, July 1999, "Vaginal Birth After Previous Cesarean Section," *Midwifery Today*, published at http://www.midwiferytoday.com/articles/acog.asp.

[92] *E.g.*, ACOG (PB #5 1999).

[93] *See, e.g.*, Flamm, B., "Once A Cesarean, Always A Controversy," 90 *Obstetrics & Gynecology* 2:312-5 (1997); Bruce L. Flamm, MD, "Vaginal Birth After Cesarean and the New England Journal of Medicine: A Strange Controversy," Birth 28:4 December 2001, available at http://www.vbac.com/hottopic/vbac-flamm.html.

That is, does the formulation of clinical standards and recommendations in favor of surgical delivery for women who have delivered in that manner before, based on non-clinical considerations such as financial reward and limitation of legal liability, violate the rights of pregnant woman who wish to refuse surgical intervention in the birthing process?

Restriction Of VBAC By ACOG For Non-Medical Reasons

ACOG acknowledges the impropriety of basing patient health recommendations on financial considerations. According to the ACOG Code of Ethics, "the welfare of the patient must form the basis of all medical judgments." It describes the "right of individual patients to make their own choices about their health care" as "fundamental", and specifically identifies financial constraints as a conflict of interest that must be disclosed to the patient. (ACOG Code 2004.)

ACOG does not dispute that VBAC is safe: "Over the past 30 years, more than 50 studies have documented the safety of VBAC."[95] For years ACOG has acknowledged the "strong consensus that trial of labor is appropriate for most women" with a history of C-section and the general agreement that the U.S. C-section rate is high.[96]

Of course, repeat C-section may be indicated for clinical reasons in the case of any particular individual patient. The question under discussion is whether ACOG discourages VBAC deliveries for non-medical reasons.

Despite its own ethical norms, there is substantial evidence that ACOG systematically and knowingly facilitates restriction of the access of pregnant women to medical and non-medical services in support of VBAC, not for the health of the mothers and babies involved, but

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[94] Wagner, M., *Born In the USA: How A Broken Maternity System Must Be Fixe To Put Women And Children First*, University of California Press, Berkeley, 2006, p. 178.
[95] Flamm 1997 p. 313.
[96] *E.g.*, ACOG Practice Bulletin #5 1999 (out of print).

for the financial benefit of its physician members in three ways: a) to increase their compensation for a delivery via selection of a more lucrative procedure; b) to protect their assets by shielding them from liability; and c) by maximizing the profitability of medical facilities in which a physician has a vested, albeit perhaps indirect, interest.

In 1997, ACOG published an article by a member physician that stated frankly: "For the physician, elective repeat cesarean offers advantages, including convenience, time savings, and sometimes increased compensation."[97]

Two years later, ACOG noted that one-third of all C-sections were performed on patients who previously delivered surgically. ACOG expressly related the increased C-section rate to the "increased medical-legal pressures" faced by American physicians arising from claims related to fetal morbidity and mortality, and admitted at the same time that the increase in C-sections as a reaction to those claims had *not* proven to be an improvement in terms of newborn outcome.[98]

Indeed, ACOG reminded its membership that complications arising from *any* unsuccessful trial of labor have increasingly "led to malpractice suits" whether or not a VBAC was involved. VBAC – a large subset of all cesareans -- was thus a tool ready to hand: reducing the number of VBACs via restriction of their availability was a way to reduce the overall number of trials of labor, in turn decreasing the specter of legal liability for malpractice during trials of labor.

It was this desire to limit members' liability to patients that led ACOG to acknowledge a "need to reevaluate VBAC recommendations."[99] One of the sources cited by ACOG in its reevaluation was entitled "Characteristics of successful claims for payment by the Florida

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[97] Flamm, B., "Once A Cesarean, Always A Controversy," 90 *Obstetrics & Gynecology* 2:312-5, 313 (1997).
[98] With few exceptions not relevant here. See VBAC Practice Bulletin # 5, p. 1.
[99] ACOG Practice Bulletin #5 1999, p. 2.

Neurologic Injury Compensation Association Fund," another ACOG publication.[100] Not surprisingly, the "reevaluated" VBAC recommendations placed a virtual chokehold on VBACs, severely limiting them to major regional hospitals that could supply the extensive battery of high-tech equipment and personnel required under the new guidelines.

ACOG Vice-President of Practice Activities, Stanley Zinberg, M.D., admitted to fellow professionals the financial nature of ACOG's discouragement of VBACs, in noting that the admittedly small risk of uterine rupture in a VBAC woman

> is often accompanied by legal action no matter what the clinical outcome or how excellent the clinical care. ***Defendant physicians and hospital are in a better position from a liability perspective*** if the physicians were present at the time of the complication.
>
> The College recognizes the implications such immediate availability has for small hospitals, for the practice patterns of obstetricians and anesthesiologists and ***for the incidence of VBAC in general***. …[101]

Dr. Zinberg characterizes VBAC as both an "obstetric emergency" and an "elective procedure".[102]

Practice Bulletin #5 is billed as part of the "clinical management guidelines for obstetrician-gynecologists," presumably rendering it subject to ACOG's ethical maxims that such decisions must be based on patient welfare and not on conflicting financial constraints. Yet the Bulletin text itself expressly manifests the non-clinical factors at play:

> It is often stated that the cost of VBAC is less than that of repeat cesarean delivery. However, for a true analysis of all the costs one has to include ***the costs to the hospital***, the method of reimbursement (i.e., per diem diagnosis-related group or capitation), and ***medical malpractice payments***. … Increased time or attendance for a woman undergoing a trial of labor results in ***increased cost to the physician***. The difficulty in assessing the cost benefit of VBAC is that the costs are not all incurred ***by one entity***.

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[100] Stalnaker, B.L., *et al.*, "Characteristics of successful claims for payment by the Florida Neurologic Injury Compensation Association Fund," Am. J. Obset. Gynecol. 1997: 177:268-271.

[101] "Optimal Goals for Anesthesia Care in Obstetrics," American Society of Anesthesiologists Newsletter, July 2003, No. 7, Vol. 67, pp. 2-3, available at http://www.asahq.org/Newsletters/2003/07_03/whatsNew07_03.html (emphasis added).

[102] "Optimal Goals for Anesthesia Care in Obstetrics," American Society of Anesthesiologists Newsletter, July 2003, No. 7, Vol. 67, p. 2, available at http://www.asahq.org/Newsletters/2003/07_03/whatsNew07_03.html.

(ACOG Practice Bulletin #5 1999, p. 3) (emphasis added).

According to ACOG practice ethics, however, there is only one entity whose welfare governs clinical judgments: the patient.[103] Yet the clinical guidelines proffered by ACOG to its member physicians expressly consider lawsuits, medical malpractice payments, rates of compensation, cost to the hospital, and cost to the physician. As Dr. Flamm had asked two years earlier in regard to earlier VBAC restrictions: "Is this good medicine or just a misguided attempt at risk management?"[104]

Nonetheless, the practice guideline set forth in Practice Bulletin #5 set severe restrictions on the practical availability of professional services to women seeking a VBAC, despite the acknowledged absence of good and consistent scientific evidence supporting the recommendation: "VBAC should be attempted in institutions equipped to respond to emergencies with physicians immediately available to provide emergency care." It further recommended that the decision to proceed with a VBAC be made not by the "patient" herself, but rather by "the patient and her physician" (ACOG Practice Bulletin #5, p. 5), despite the ethical prescription for the fundamental right of individual patients to make their own choices about their health care.

In 2004 ACOG replaced Practice Bulletin #5 with Practice Bulletin #54. ACOG had apparently learned something from the controversy generated by its candor in 1999: its previously-frank references to "malpractice suits" were omitted. Nonetheless, the key restrictive provision functionally limiting the availability of VBAC services was carried forward and is in effect to the present day: "VBAC should be attempted in institutions equipped to respond to

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[103] Conflicts between the welfare of the mother giving birth and the baby and/or fetus are beyond the scope of this paper. For purposes of the issue at hand, it is safe to assume that the discussion is limited to those instances where the interests of the mother and the fetus or newborn are in alignment.

[104] Flamm, B., "Once A Cesarean, Always A Controversy," 90 *Obstetrics & Gynecology* 2:312-5, 315 (1997).

emergencies with physicians immediately available to provide emergency care."[105] This language is a direct carry-over from the 1999 Bulletin, and had been previously criticized for its adverse impact on availability of VBAC services:

> The first Level C recommendation, "VBAC should be attempted in institutions equipped to respond to emergencies with physicians immediately available to provide emergency care," has a huge impact on the system of maternity care in the United States that goes far beyond obstetric practice. If this policy is followed, it drastically reduces or eliminates several options available to women with previous cesarean section, including having their birth at home, in a freestanding birth center or in a small community hospital. Because of all the unnecessary cesarean section in the past, American women with a scarred uterus are a significant minority of pregnant women—in the neighborhood of 15 percent. If the nearest large hospital is at some distance, it makes a family-centered birth difficult or impossible and is likely to eliminate continuity of care throughout pregnancy and birth. Scientific data show such continuity of care significantly improves birth outcomes.[106]

According to another medical commentator:

> The conclusions of the current study and the phrase "immediately available" from the ACOG bulletin have significant implications for both anesthesia and obstetric care providers whose practices have been based on a home call system. No longer is it simply enough to make the incision within 30 min of the decision for cesarean section; now they must remain immediately availablewhen patients attempt VBAC if they want to comply with these recommendations. To do so practices must be altered to take "in-hospital," which is simply not feasible in many rural practices. Alternative solutions include not allowing patients to attempt VBAC (elective repeat cesarean sections only) or transferring patients that desire a trial of labor to a tertiary care center where the care providers are immediately available for emergencies.[107]

ACOG's clear ulterior financial motives are also at play in the "reevaluated" ACOG standards:

> ACOG's primary allegiance to the needs of its members over the needs of women and families requires their recommendations to be suspect unless confirmed by overwhelming scientific evidence. As ACOG recommendations come from a single-specialty organization, they always must be carefully evaluated as to bias and should never be the

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[105] ACOG Practice Bulletin #54 (2004), p. 6.
[106] Wagner, M., "What Every Midwife Should Know About ACOG and VBAC: Critique of ACOG Practice Bulletin No. 5, July 1999, "Vaginal Birth After Previous Cesarean Section," *Midwifery Today*, published at http://www.midwiferytoday.com/articles/acog.asp.
[107] D'Angelo, R., Comment On "Neonatal Morbidity Associated with Uterine Rupture: What Are the Risk Factors?", by Bujold E., *American Journal of Obstetrics and Gynecology* 2002; 186:311-4, Comment published at *Obstetric Anesthesia Digest* September 2002:132.

> sole basis, nor even the most important justification, for maternity care policy in the United States.[108]

Independent Research Acknowledges the ACOG Problem

Researchers from different disciplines are in accord with ACOG's own admissions on its role in restriction of VBAC services and availability. For example, economists at Tulane University have written:

> Theoretical and empirical studies suggest that risk of malpractice lawsuits encourages physicians to practice "defensive medicine", utilization of medical resources beyond its optimal level of use. … Results suggest that a higher degree of malpractice risk increases the probability of C-section delivery.[109]

One doctor describes it this way:

> Perhaps the most distressing aspect of the continuing VBAC saga involves the specter of huge malpractice claims. Many physicians earnestly want to avoid unnecessary repeat cesarean operations but fear that they will be found legally liable if any untoward event occurs during a trial of labor. ... at least one major medical malpractice insurance company (Cooperative of American Physicians, Inc., Mutual Protection Trust) already has mailed a modification of [the VBAC] consent form …. No risks for elective repeat cesarean are listed. … Widespread implementation of this or similar consent forms essentially would mean the end of VBAC. I think that would be a serious mistake. … On a national level, giving up VBAC would mean performing an additional 100,000 cesareans every year. It is unlikely this huge number of operations could be performed without many seriuos complications and perhaps even some maternal deaths.[110]

A disturbing study released in 2001 identified a number of non-clinical factors as affecting physician choice to deliver surgically. The aim of the study was to examine obstetricians' decisions to perform or not to perform cesarean sections, and to elucidate which factors were most important in deciding the birth mode. The authors of the study identified forty-

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[108] Wagner, M., "What Every Midwife Should Know About ACOG and VBAC: Critique of ACOG Practice Bulletin No. 5, July 1999, "Vaginal Birth After Previous Cesarean Section," *Midwifery Today*, published at http://www.midwiferytoday.com/articles/acog.asp.

[109] Dhankhar, P., *et al.*, "Threat of Malpractice Lawsuit, Physician Behavior and Health Outcomes: Testing the Presence of Defensive Medicine," Annual Meeting Paper, American Economic Association (2005), published at http://www.aeaweb.org.annual_mtg_papers/2005/0107_0800_1213.pdf (dividing data into two groups, necessary c-section and unnecessary c-section).

[110] Flamm, B., "Once A Cesarean, Always A Controversy," 90 *Obstetrics & Gynecology* 2:312-5, 314 (1997).

two birthing predictor variables, which were divided into three categories: 1) Maternal clinical characteristics present at time of labor, such as preeclampsia; 2) baby clinical characteristics, such as the so-called "fetal distress" and malpresentation; and 3) patently non-clinical factors, such as those related to the physician's practice setting, financial parameters, legal issues, and practitioner characteristics.[111]

The authors concluded that non-clinical factors were "important" in determining the birthing mode, and "emphasized that a clinician's decision on the appropriate birthing mode is based not only on scientific understanding but on other factors, such as the mother's attitude toward the birthing mode [and] the malpractice environment …." Physician convenience also appeared to be a factor: delivery occurring during the day shift at a hospital was found to have the effect of increasing the likelihood of a cesarean section. The authors interpreted the results as suggesting possible ways of reducing the cesarean section rate, including by educating the mother on "advantages of a vaginal birth versus a cesarean section" and "[e]ducating physicians about the appropriate use of induction."

In one geographically localized study, it was shown that after issuance of Practice Bulletin #5, independent practitioners shut down their VBAC practice because they could not treat patients in their clinic setting and simultaneously attend a VBAC patient at a community hospital.[112] The authors of the study provided additional detail on economic considerations acknowledged but glossed over in the Bulletin itself:

> Cesareans produce hospital revenues of $ 14,000 to $ 17,000 each, while vaginal deliveries produce $ 6,000 to $ 8,000 each. Additionally, the hospital stands to receive additional revenues because of the increased re-hospitalization rates related to cesarean

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[111] Martin MacDowell, DrPH, Eugene Somoza, MD, PhD, Kenneth Rothe, PhD, Richard Fry, MD, Kim Brady, MD, Albert Bocklet, PhD, "Understanding Birthing Mode Decision Making Using Artificial Neural Networks," *Medical Decision Making* (Nov.-Dec. 2001) 21; 433.

[112] Myers, M., "ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?" 49 S.D. L. REV. 526, 535 (2003).

> delivery. As for the OB/GYN practice? Vaginal deliveries produce no surgical fees. The record-high cesarean rate is likely to become an abstraction for executives and physicians who observe its contribution to their bottom lines.
>
> The practical effect of the standard has been to confer exclusive legitimacy for the performance of VBACs upon university and tertiary-level medical centers staffed by surgeons, anesthesiologists, and surgical teams. These islands of concentrated medical technology are not conveniently accessible to the overwhelming majority of women who desire a VBAC and wish not to return to the clinically-discredited era of "once-a-cesarean, always-a-cesarean." The profit-and-loss practicalities of medical practice prevent specialists and family practice physicians from leaving their private clinics to attend at a community hospital the labor of women awaiting a VBAC. … Whereas market restraints are acknowledged for their infliction of economic harm, medical markets have the unique ability to inflict clinical harm, injury, and even death upon consumers …. The ACOG standard is illustrative of the capacity of a private organization, exercising peer authority, to impose upon the broader community mandates generally reserved to government.[113]

Restraint Of Trade Reducing Output Of Services

In order to appreciate fully the extent to which the rights of individuals are violated by ACOG's influence on VBAC services, one must analyze that influence not only in regard to American health policy (discussed above), but also in light of American economic policy supporting a competitive free market.[114]

American public policy against monopolies is formalized in the federal Sherman Act, which provides that "[e]very person who shall monopolize or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States . . . shall be deemed guilty of a felony."[115] Monopoly power is "the power to control market prices or exclude competition."[116]

General Statutory Scheme. The basic antitrust statutes are few in number: The Sherman Act of 1890; the Clayton Act, first enacted in 1914 and significantly amended in 1936 by the

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[113] Myers, M., "ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?" 49 S.D. L. REV. 526, 528-29 (2003).
[114] *See generally* Barlett, D., *et al.*, *Critical Condition: How Health Care in America Became Big Business – and Bad Medicine* (New York: Doubleday 2004).
[115] 15 U.S.C. §§ 1-11 (1988).

Robinson-Patman Act and in 1950 by the Celler-Kefauver Antimerger Act;[117] and the Federal Trade Commission Act of 1914.[118]

The Sherman Act prohibits contracts, combinations, and conspiracies in restraint of trade, and also prohibits monopolization. The high value our society places on free trade is illustrated by the gravity of the sanctions. Violation of the Sherman Act can result in substantial fines and, for individual transgressors, prison terms. In addition, court orders restraining future violations are also available. These provisions are enforced primarily by the Antitrust Division of the Justice Department.

The Clayton Act, which deals with specific types of restraints including exclusive dealing arrangements, tie-in sales, price discrimination, mergers and acquisitions, and interlocking directorates, carries only civil penalties and is enforced jointly by both the Antitrust Division and the Federal Trade Commission.

The Federal Trade Commission Act, administered solely by that agency, is a catch-all enactment which has been construed to include all the prohibitions of the other antitrust laws and, in addition, may be utilized to fill what may appear to be loopholes in the more explicit regulatory statutes.

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[116] *United States v. E.I. DuPont de Nemours & Co.*, 351 U.S. 377, 391 (1956).
[117] 15 U.S.C. § 17.
[118] 15 U.S.C. §§ 41-58.

Rule of Reason and Per Se Offenses. Section 1 of the Sherman Act prohibits "every contract, combination . . . or conspiracy in restraint of trade . . . ." that is unreasonable. This "rule of reason" is the hallmark of judicial construction of the antitrust laws. The anti-competitive consequences of a challenged practice are weighed against the business justifications upon which it is predicated and its putative pro-competitive impact, and a judgment with respect to its reasonableness is made.[119]

Such an approach has obvious shortcomings. For one thing, reasonableness is an ephemeral concept, and whether a particular course of conduct will ultimately be found to be reasonable is not easy to predict when new business arrangements are contemplated. Moreover, the task of enforcing a regulatory scheme based on such a theory can be staggering.

Trade Associations. "Trade associations, by their very nature, bristle with antitrust problems. Practically by definition the requisite agreement is present, and the inquiry focuses on the nature of the members' concerted activity."[120] ACOG had been described as "the largest trade union for obstetricians and gynecologists in the United States"[121] and its VBAC recommendation has been singled out for its restrictive effect on VBAC services:[122]

> In addition to this impact on women and families and birth outcomes, this recommendation also has a major impact on community-based midwives, family physicians, birth centers and small hospitals.[123]

Per se offenses such as price fixing and market division are obviously improper for an association. Of course, trade associations may properly act, under supervision, in many areas.

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[119] *See generally* Sullivan, L., *The Law Of Antitrust: An Integrated Handbook* (Thomson West, Minneapolist 2006).
[120] Steuer, R., "Executive Summary Of the Anti-Trust Laws," published at http://library.findlaw.com/1999/Jan/1/241454.html.
[121] International Cesarean Awareness Network, Inc., [hereinafter ICAN] ICAN In the News, ICAN Criticizes ACOG's Statement on Ethical Cesareans (Nov. 10, 2003), at http://www.ican-online.org/news/111003.htm.
[122] ACOG Practice Bulletins #5 (1999), 54 (2004).

Among these, statistical reporting of various types -- past costs, production, sales, and the like -- is the most usual. So also, standardization may be a proper association activity as long as standards which serve to lessen competition are avoided and all members are free to disregard them.

Monopolization. Antitrust is also concerned with market structure, and it prohibits structural phenomena likely to substantially lessen competition or to amount to monopolization. Antitrust is premised on the belief that a competitive economy can best be achieved by maintaining markets with a significant number of sellers. Hence, to a considerable extent, the structural aspect of the law focuses on avoiding or remedying the concentration of market power in a few firms with large market shares.

Section 2 of the Sherman Act makes it unlawful to monopolize, attempt to monopolize, or conspire to monopolize a line of commerce. It is significant that the statute does not speak in terms of the existence of a monopoly; rather, its focus is on the act of monopolization, which requires something more. The offense of monopolization , which is not purely structural, has two elements: (1) possession of monopoly power in the relevant market, and (2) willful acquisition or maintenance of that power.

Monopoly power. This is the power to control prices or exclude competition. As a practical matter, such power is measured by the alleged monopolist's share of the relevant market. Absolute monopoly in the economic sense -- 100 percent of the market -- is a rare phenomenon, raising the question of how large a share a firm must possess to come within the statutory concept. Although there is no hard and fast rule, any market share of 50 percent or higher is sufficient to be of concern.

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[123] Wagner, M., "What Every Midwife Should Know About ACOG and VBAC: Critique of ACOG Practice Bulletin No. 5, July 1999, "Vaginal Birth After Previous Cesarean Section," *Midwifery Today*, published at

Willful acquisition or maintenance. Once monopoly power is found the question remains: Was it willfully acquired or maintained? This is ephemeral and difficult to determine. The statute does not require that monopoly power be abused or intentionally exercised to drive out competition, although such conduct, if present, is sufficient to make out a violation. Nor does the element of willfulness entail an evil intent to eliminate competitors. Conscious acts designed to further or maintain a monopoly market position will suffice.

Attempt to Monopolize. Section 2 of the Sherman Act also prohibits attempts to monopolize by companies that do not possess monopoly power but engage in anticompetitive conduct designed to achieve it. To prove an attempt to monopolize, one must establish that the defendant had a specific intent to achieve monopoly; that it acted in an anticompetitive manner designed to injure its actual or potential competition; and that there was a dangerous probability that monopoly power would in fact be achieved. Since companies that actually possess monopoly power are an industrial rarity, most Section 2 litigation involves allegations of attempts to monopolize; and it is the "dangerous probability of success" element on which the resolution of most cases turns.

Anti-Trust And Birth

Profit maximization has approximately the same presence in health care as it does banking, auto sales, the practice of law, and other market niches.[124] As noted above, ACOG is functionally a trade union. Its VBAC policies resonate in the anti-trust context. The so-called "clinical" restraints on VBAC services have driven many qualified competitors out of the

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http://www.midwiferytoday.com/articles/acog.asp.

[124] *See, e.g.*, Daniel Haley, Politics in Healing: The Suppression and Manipulation of American Medicine (Potomac Valley Press 2000); James P. Carter, M.D., Dr. P.H. Racketeering in Medicine: The Suppression of Alternatives, (Hampton Roads Publishing 1992); Masid Ali, M.D., Rats Drugs and Assumption, (Life Span Press 1995); Rosemary Gibson & Janardan Prasad Singh. GIBSON, Wall of Silence, (LifeLine Press 2003); Fitzhugh Mullan, M.D., Big Doctoring in America, (University of California 2002); Hal A. Huggins, D.D.S., M.S. & Thomas E. Levy,

market, particularly direct-entry midwives and family-practice physicians. This in turn has the inevitable effect of making such providers effectively unavailable to women who would otherwise utilize their services.

The problem is compounded by the refusal of many hospitals to permit VBAC on the premises except pursuant to the ACOG Practice Bulletin Guidelines, for fear of compromising their health insurance coverage or increasing their malpractice insurance rates, thus forcing a woman who would prefer vaginal delivery or home birth to submit herself to the heightened risk of surgical intervention in a hospital setting. This also effectively limits her selection of care providers:

> [M]ost [direct-entry] midwives can only practice outside the hospital and most [certified nurse midwives] can only practice inside of hospitals. Thus … to choose a particular kind of midwife is also to choose a particular place of birth.[125]

Even more, to choose a non-physician care provider is to choose the place of birth; and to choose a non-ob-gyn provider (even a family physician) is to choose a place of birth – if such providers can be found who are willing to buck the ACOG trend.

In 2003 the ACOG Committee on Ethics issued a statement declaring elective cesareans to be "ethical," thereby providing its members with "an ethical pass to perform a procedure that is proven more dangerous to women and babies."[126] ACOG acknowledged cesarean risk in a release summarizing the results of a study that found "a cesarean delivery significantly increased a woman's risk of experiencing a pregnancy-related death (35.9 deaths per 100,000 deliveries

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M.D., J.D., Uninformed Consent (Hampton Roads Publishing 1999); Eugene D. Robin, M.D., Matters of Life and Death: Risks vs. Benefits of Medical Care (W. H. Freeman & Co. 1984).

[125] Davis-Floyd, R., *Mainstreaming Midwives: The Politics of Change*, Routledge, New York 2006, pp. 32-33; Wagner, M., *Born In the USA: How A Broken Maternity System Must Be Fixe To Put Women And Children First*, University of California Press, Berkeley, 2006, p. 534.

[126] Myers, M., "ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?" 49 S.D. L. REV. 526, 527 (2003); ICAN In the News, ICAN Criticizes ACOG's Statement on Ethical Cesareans (Nov. 10, 2003), at http://www.ican-online.org/news/111003.htm.

with a live-birth outcome) compared to a woman who delivered vaginally (9.2 deaths per 100,000).[127]

On close inspection, it is not difficult to discern the economic turf battle that is raging:

> Maternity care is big business in the U.S., especially for hospitals. Of total hospital stays for women, 25% are for pregnancy and childbirth ("Care of Women in U.S. Hospitals, 2000" HCUP Fact Book No. 3). In 1999, delivery accounted for about 270 hospitalizations for every 10,000 women (Women's Health USA, 2002). Obstetricians are important to a hospital's financial success for a number of reasons, including the fact that they influence around 11%, or $30 million, of inpatient charges through referrals to other physicians within the hospital (Hanold, K C, "OB/GYNs Offer a Rich Source of Referrals" MHS Fall 2002). In other words, obstetrical care is still a major marketing tool for hospitals; when a woman needs hospitalization for herself or for a family member, she will tend to stick with the hospital where she gave birth. …
> When we think about costs and "cost effectiveness" we usually think about the cost to us, the consumers (or to our insurance carrier or HMO). We can see that our costs will vary by setting:

Fees	**Home Birth**	Birth Center	Hospital	Cesarean Section
Total	$2,300-$5,000	$3,500-$8,300	$4,300-$16,000	$9,300-$26,000 (includes average 4-day hospital stay)

> (O'Mara, P. Having a Baby, Naturally. 2003. p. 322. Based on figures published in 1999.)
>
> Consider that 99% of births occur in hospitals, of which more than ¼ are cesarean sections, and that home birth costs as little as one sixth the cost of an uncomplicated vaginal birth in the hospital. …
>
> There is an unspoken assumption that physicians' decisions should not be questioned, so there is no regulation by disinterested parties. There is virtually no consumer pressure. There are no restraints on anti-competitive practices. There are no meaningful consumer protections. There is no accountability for the health and well-being of mothers and babies.

Despite these facts, bringing anti-trust policy to bear on provision of birthing services has proven difficult, especially where the "injured" parties are not economic competitors deprived of a livelihood, but patients who are effectively denied access to a certain type of service. Doctors

[127] *E.g.,* Myers, M., "ACOG's Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?" 49 S.D. L. REV. 526, 527-28 (2003); ACOG Press Release, 2003.

enter into agreements with hospitals, insurers and practice partners by virtue of which they may be held accountable to those entities; there has been little in the way of regulatory or other institutional mechanisms to hold doctors accountable to patients, however.[128]

Under most state laws, a hospital's refusal to appoint a health care professional to its medical staff is not subject to judicial review because of the understandable reluctance of judges to substitute their judgment for that of decision makers in private organizations.[129]

Even direct Sherman Act challenges often fail as a vehicle due to the difficulties inherent in proving key elements of such a claim. Generally speaking, the continuing reliance of federal courts on economic theory in antitrust cases has had a profound impact, because the economic approach demands proof that output is restricted in order to show the required foreclosure of competition and, thus, establish an antitrust violation.[130]

According to Amnesty International, nursing and midwifery services contribute to international health improvement *inter alia* by promoting gender equality via educating girls and women about health issues; by reducing child and maternal mortality; and by delivering maternal and child health services. Yet these practitioners are stymied, and therefore their would-be clients denied these benefits, when competition with ob-gyns is suppressed in favor of a medical monopoly not justified by the medical evidence.

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[128] Rodwin, Marc A., *Medicine, Money and Morals: Physicians' Conflicts of Interest* (1993), pp. 11-34, 162-75.
[129] *See, e.g.*, *Shahawy v. Harrison*, 875 F.2d 1529 (11th Cir. 1989) (physician); *Adkins v. Sarah Bush Lincoln Health Center*, 544 N.E.2d 733 (Ill. 1989) (physician); *Barrows v. Northwestern Memorial Hospital*, 525 N.E.2d 50 (Ill. 1988) (physician); *Lapidot v. Memorial Medical Center*, 494 N.E.2d 838 (Ill. App. 1986) (physician); *Rao v. St. Elizabeth's Hospital*, 488 N.E.2d 685 (Ill. App. 1986) (physician).
[130] *E.g., Marrese v. American Academy of Orthopaedic Surgeons*, 1991-1 Trade Cas. (CCH) P69,398 (N.D. Ill. 1991) (first inquiry is whether the defendant possesses market power).

Democratic, non-legislative methods are sometimes relied on to correct monopolistic tendencies. One important method in a free society is the use of exit, that is, consumers exiting from one provider to "purchase" medical services elsewhere.[131]

The women's health movement has been cited as one example of the "exit" correction to monopolistic tendencies.[132] Yet exit is not a feasible remedy where monopolistic restraints have thwarted alternative providers. Doctors "act as gatekeepers for many health care resources."[133]

> While the women's health movement has had some positive effects on medicine, change has been slow and partial. Professional power is still strong and often determines how health services are performed. Despite the women's movement's efforts to allow women greater control over childbirth, trends exist that counter such control. For example, births by cesarian section in the United States have increased steadily from 4.5% in 1965 to 24% in 1986 and stayed around this level until 1991. Despite efforts by women's groups and consumers, women frequently have been forced to have cesarean sections against their will … the women's movement has had only limited effects on changing practices.[134]

One silver lining: antitrust jurisprudence is gradually evolving to inquire whether certain conduct reduces the output of products or services, as opposed to a stricter economic-impact analysis (Sfikas 1991). Viewed through this lens, the ACOG VBAC conduct runs counter to the American policy of anti-monopolistic provision of services.

As discussed *supra*, the so-called "clinical" constraints on VBAC services have driven many qualified competitors out of the market, particularly direct-entry midwives, nurse

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[131] See Albert O. Hirschman, Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States (1970); Albert O. Hirschman, Exit and Voice: An Expanding Sphere of Influence, in Rival Views of Market Society and Other Recent Essays 77-101 (1986); Brian Barry, Review Article: "Exit, Voice, and Loyalty", 4 Brit. J. Pol. Sci. 79 (1974); A.H. Birch, **Economic** Models in Political Science: The Case of "Exit, Voice, and Loyalty', 5 Brit. J. Pol. Sci. 69 (1975); Albert O. Hirschman, "Exit, Voice, and Loyalty": Further Reflections and a Survey of Recent Contributions, Soc. Sci. Info., Feb. 1974, at 7-26, reprinted in Milbank Q., Summer 1980, at 430-53; Rudolph Klein, Models of Man and Models of Policy: Reflections on Exit, Voice, and Loyalty Ten Years Later, Milbank Q., Summer 1980, at 416-29.

[132] Rodwin, M., "Patient Accountability and Quality of Care: Lessons From Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements," 20 Am. J. L. and Med. 147, 158 (1994).

[133] Rodwin, M., "Patient Accountability and Quality of Care: Lessons From Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements," 20 Am. J. L. and Med. 147 (1994).

practitioners and family physicians. This in turn has the inevitable effect of making such providers effectively unavailable to women who would otherwise utilize their services.

This, then, is the nexus between the anti-competitive nature of ACOG policies, and the human rights of individual American women: deprivation of entire portions of the maternity-care spectrum routinely available to women in other countries. Even in those instances when are able to avail themselves of a direct-entry midwife, for example, their care may be compromised due to factors beyond their control. Physician resistance to midwifery and out-of-hospital birth may result in denigration of the pregnant women involved, or even denial of services in the form of refusal to accept an emergency transport to hospital from a home birth due to failure to progress, medical emergency, or exhaustion of the mother: midwives

> and their clients sometimes suffer in extreme ways from the effects of [negative] stereotypes, as the home-to-hospital transport stories … describe. The negative reactions midwives encounter when they transport a client to the hospittal (not to mention those they also encounter in state legislatures) vivify the problematic nature of the interface between midwives and medical practitioners …. It is one thing to proudly hold a countercultural space in which women can make alternative choices, and another to watch your clients suffer the effects of the negative stereotyping of midwives. Thus … they are keenly aware of the need … to protect their clients from being medically mistreated because they chose a home-birth midwife.[135]

It is generally recognized that the interests of the consumer are usually "better served by competitive forces in the market place."[136] "There is a generalized concern that expresses itself in various governmental policies, some being part of decisional and statutory law, against combinations and agreements that operate to restrain or encumber trade.[137]

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[134] Rodwin, M., "Patient Accountability and Quality of Care: Lessons From Medical Consumerism and the Patients' Rights, Women's Health and Disability Rights Movements," 20 Am. J. L. and Med. 147, 163 (1994) (citations omitted).
[135] Davis-Floyd, R., *et al.*, *Mainstreaming Midwives: The Politics of Change* (Routledge New York 2006), p. 168.
[136] *Vermont National Bank* v. *Chittenden Trust Co.,* 143 Vt. 275, 261, 465 A.2d 284, 287 (1983); *Addison County Automotive, Inc. v. Church*, 144 Vt. 553, 557, 481 A.2d 402 (1984).
[137] *See, e.g.*, *State* v. *Heritage Realty,* 137 Vt. 425, 407 A.2d 509 (1979); The Consumer Fraud Act, 9 V.S.A. sec. 2453; The Sherman Anti-Trust Act, § 1, 15 U.S.C. sec. 1 (1974); The Clayton Act, § 3, 15 U.S.C. sec. 14 (1914); The Federal Trade Commission Act, § 5(a)(1), 15 U.S.C. sec. 45 (a)(1)(1960).

In this sense, ACOG's activity violates the rights of pregnant women not only as patients, but as consumers of goods and services in a free market; and it is doing so on a patently discriminatory basis: pregnant are singled out for this particular brand of abasement and jeopardy.

The U.S. Department Of Health and Human Services has recommended collaboration between physicians and midwives as one avenue of enhancing availability of birthing services.[138] According to its "Commentary On Obstetricians And Midwives:"

> In 1993, the American College of Obstetricians and Gynecologists (**ACOG)** established an initiative to encourage the use of collaborative models in women's health care. … Patients respond positively to care provided in collaborative practices, as has now been confirmed by ACOG studies of patient satisfaction. … Rather than suggest that one type of non-physician provider can deliver the majority of women's health care unaided, ACOG advocates collaborative practice by a variety of providers who, working with physicians, can best serve women's health needs. … We believe, therefore, that the most effective systems are not one provider over another but collaborative teams of physicians and advanced practice professionals combining their skills to maximize treatment and educational strategies that can improve the health of women.

ACOG and its members have moved advisedly to restrict the output of birthing services to women not only in the ways discussed above (VBAC restrictions, promotion of c-sections generally, etc.), but also by targeting midwives to discourage their provision of birthing services. These efforts include educational or propaganda efforts (depending on one's point of view) condemning home birth as a form of child abuse, and otherwise discouraging out-of-hospital births.

Beyond that, ACOG through its divisions has taken concrete steps to thwart the provision of non-physician birthing services. For example, the Wisconsin Section of ACOG issued a notice to its members that it "would like to document any adverse outcomes that physicians might

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[138] Lawrence, H., "Commentary On Obstetricians And Midwives," 1997 U.S. Department of Health and Human Services, Public Health Rep 1997; 112: 395 September/October, 1997.

encounter in their practice by patients who are assisted by professional midwives."[139] To what use might such anecdotal reports be put? ACOG is the self-described "voice of women's health" (albeit without benefit of the blessing of the women for whom it claims to speak) and as such urges its members "to become more active at every level of government".[140] ACOG educates its members that it is "[m]ost difficult to have an effective legislative presence without a dedicated lobbyist" and that a state section "must develop its legislative committee and its legislative agenda before hiring a lobbyist".[141] ACOG has an active "Government Relations Committee" that sponsors an Annual Lobbyist Roundtable and encourages the "growing" of "ACOG's advocacy in the state capitals" to defeat legislative initiatives that would legalize, regulate or otherwise encourage the practice and professionalization of midwifery:

> On the issue of midwives, the committee discussed how the lack of comparative data on midwife-assisted birth outcomes hinders our efforts as ob-gyns, and explored ways to assist Fellows in responding to midwife bills in their state. It was proposed that ACOG collect anecdotes from Fellows who have been back-up or on call for midwife-assisted deliveries that ended in an adverse outcome.[142]

It is no surprise that ACOG did not call for "anecdotes" about good-outcome midwife services, nor for bad-outcome ob-gyn deliveries. Negative publicity is typically generated by a bad-outcome midwife-attended birth, but is "rarely applied to negative hospital outcomes".[143] A leading scholar on the anthropology of reproduction in the United States, Robbie Davis-Floyd, writes of the "damaging stereotypes hospital practitioners tend to create and disseminate about direct-entry midwives" and observes:

> A further barrier to midwifery care has to with the negative publicity that occurs almost every time there is a bad outcome at a home birth. Deaths in the hospital of baby or

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[139] "Adverse Outcomes Midwife Births, ACOG Wisconsin Section Release, available at http://www.acog.org/acog_sections/dist_notice.cfm?recno=17&bulletin=1821.
[140] *E.g.*, ACOG News Release, May 9, 2007, available at http://www.acog.org/from_home/publications/press_releases/nr05-09-07-1.cfm.
[141] ACOG District VIII Annual Meeting Minutes, November 7, 2006.
[142] ACOG District VIII Annual Meeting Minutes, November 7, 2006.
[143] Davis-Floyd, R., et al., *Mainstreaming Midwives: The Politics of Change* (Routledge New York 2006), p. 169.

> mother are rarely publicized because the hospital constitutes the cultural standard for safety, and physicians tend to protect their own from public view. Thus a death at home rings loud cultural alarm bells, sounding the culturally ingrained message that home birth is an irresponsible choice for mothers, and that home-birth midwives must be far less competent than hospital-based practitioners.[144]

One can readily perceive the damage this wreaks on the midwives themselves, emotionally, professionally and financially. More to the point of this paper, however, is the damage done the laboring mother who has exercised her right to choose the services of a midwife and give birth at home. Both midwives "and their clients suffer in extreme ways from the effects of such stereotypes."[145]

> One of the most significant and challenging of these barriers is *hospital and physician resistance to midwives*, which is sometimes purely economically motivated, and sometimes motivated by an erroneous belief that midwives are not really competent professionals – at least not as competent as the doctors themselves. CNMs [Certified Nurse Midwives] experience physician or hospital administrator resistance when they are overscrutinized (usually when someone is looking for a reason to get rid of them) or fired outright in large numbers, or when physicians refuse to provide backup for their birth center, homebirth practices, and even hospital practices, and/or harrass the few physicians that do. …
>
> DEMs [direct entry midwives] experience hysician resistance in the form of the same refusal of backup care, insulting treatment in the hospital when they transport a patient, investigation of their practices by physicians determined to shut them down … and heavy lobbying by professional medical organizations against legislation to legalize and regulate DEMs in various states.[146]

According to another observer,

> most obstetricians are vehemently opposed to midwives and have gone to great lengths to drive them out of business. Far beyond a mere territorial battle between two groups of health care professionals, the persecution of midwives in this country has taken on the fervor of an old-fashioned witch hunt. The result is fewer options for women. In many regions of the United States, a pregnant woman who wants the care of a midwife can't

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[144] Davis-Floyd, R., et al., *Mainstreaming Midwives: The Politics of Change* (Routledge New York 2006), pp. 167, 532.
[145] Davis-Floyd, R., et al., *Mainstreaming Midwives: The Politics of Change* (Routledge New York 2006), p. 168.
[146] Davis-Floyd, R., et al., *Mainstreaming Midwives: The Politics of Change* (Routledge New York 2006), pp. 527-28.

get it unless she's willing to go outside mainstreamt health care channels, and, in some areas, even risk being persecuted and/or prosecuted herself.[147]

Change Proposal: Transparency and Litigation

OPENNESS, honest and complete OPENNESS – that is the first condition of health in all societies.
Aleksandr Solzhenitsyn

> Changing physicians' practice patterns to reduce cesarean birth rates has not been easily accomplished. Government agencies, professional associations, physician leaders, managed care organizations, and consulting groups all have struggled with this issue for more than 20 years. Although the national and state rates are now 10% to 20% below their peak in 1988 (which translates to a 1% to 3% reduction in the total cesarean rate), most are not near the national Healthy Person 2000 goal of 15%. … midwife-centered care has led to some of the lowest cesarean birth rates in the United States. … changing behaviors of highly educated adults is not an easy task.[148]

The American founders believed "in the enlightened choice of the people, free from the interference of a policeman's intrusive thumb or a judge's heavy hand." *Ginzburg v. U.S.,* 383 U.S. 463, 498 (Stewart, J.). The free flow of information is a matter not only of legal rights, but also of good public policy in the realm of scientific endeavors. Andrei Sakharov won both the Nobel Peace Prize and the Nobel Prize for Physics. He stated:

> I am likewise convinced that freedom of conscience, together with the other civic rights, provides the basis for scientific progress and constitutes a guarantee that scientific advances will not be used to despoil mankind, providing the basis for economic and social progress, which in turn is a political guarantee for the possibility of an effective defense of social rights. … people [are] deprived of contact with nature and of normal human lives in the traditional sense of the word …. We need reform, not revolution. We need a pliant, pluralist, tolerant community, which selectively and tentatively can bring about a free, undogmatic use of the experiences of all social systems. … [L]ike faint glimmers of light in the dark, we have emerged for a moment from the nothingness of dark unconsciousness of material existence. We must make good the demands of reason and create a life worthy of ourselves and of the goals we only dimly perceive.

(Sakharov 1975).

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[147] Wagner, M., *Born In the USA: How A Broken Maternity System Must Be Fixe To Put Women And Children First*, University of California Press, Berkeley, 2006, p. 10.
[148] Main, E., "Reducing Cesarean Birth Rates With Data-driven Quality Improvement Activities," 103 *Pediatrics* 1, pp. 374-83, at p. (1999).

Science provides the moniker for one offspring of the free-speech evolution: "transparency." To scientists, a transparent object is one that does not conceal what is on the other side. To social scientists, transparency in government and in non-governmental institutions of public importance is a counterpoint to secrecy, and facilitates openness and participation through public accessibility, review and debate. Transparency discourages abuse of power by those who hold it, *inter alia* by making it easier to discern poor judgment or intentional wrong-doing on the part of decision-makers, and hold them accountable to improve the system.

Transparency has been applied in many different contexts to promote accountability within government. For example, the U.S. Bankruptcy Courts rely heavily on required disclosures and the transparency of bankruptcy proceedings to avert corruption and promote equity, and similar techniques are utilized in family courts vis-à-vis distribution of the marital estate.[149] The U.S. General Accounting Office has called for greater transparency in federal spending and record-keeping to promote accountability.[150]

The principle of transparency is applied not only to governments, but to corporations and other non-governmental entities within a country. The call for enhanced transparency has risen in volume since the Enron disaster. Even the U.S. Securities and Exchange Commission joined the fray. "SEC warns investors need transparent disclosure in wake of Enron debacle."[151]

According to one scholar, a "physician-based healthcare system that has grown beyond critical bounds … obscures the political conditions that render society healthy; and it tends to mystify and to expropriate the power of the individual to heal himself and to shape his or her environment."[152]

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[149] Breen 2004.
[150] U.S. GAO 2003.
[151] Rankin, K., "Assurance Forum," *Accounting Today*, January, 2002 by Ken Rankin.
[152] Ivan Illich, *Medical Nemesis: The Expropriation of Health* p. 9 (Random House 1976).

The doctrine of informed consent, as applied in the context of childbirth, creates a duty of disclosure upon a physician to present her patient with information on not only the material risks involved in undergoing natural childbirth, but also the risks associated with having a cesarean section.[153] In the childbirth context, physicians' "bias towards cesarean sections may influence their ability to provide adequate information about childbirth methods. Physicians who find it in their best interest to perform the surgery may reveal incomplete information to a patient deciding between a cesarean or natural childbirth. This practice violates the physician's fiduciary duty to her patient."[154]

Transparency is called for in the larger American birth context, as well: free access to the data and procedures utilized by ACOG, as the standard-setter for American birthing practices, in its formulation of clinical recommendations.

Not surprisingly, the corporate world resists opening its secrets to outside scrutiny. It often cites the "trade secret privilege" to justify drawing a veil over its workings. The trade secret doctrine, however, is an "oddball" privilege[155]. A leading commentator has observed:

> [T]he privilege is difficult to justify, especially when the law does not recognize privileges for many more deserving sorts of information; *e.g.*, parent child communications.[156] ... To say that the basis of trade secret law is "commercial ethics" begs the question of its justification by assuming business secrecy is justified. As the example of science suggests, it is quite possible to imagine social institutions that involve the same competing values of individualism, competition and innovation as the commercial world yet which embrace an ethics of openness.[157]

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[153] Physicians are required to disclose (1) the risks of a particular method of treatment; (2) alternative methods of treatment; (3) the risks relating to such alternative methods of treatment; and (4) the results likely to occur if the patient remains untreated. *Canterbury v. Spence*, 464 F.2d 772, 781-82 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972); *Crain v. Allison*, 443 A.2d 558, 561-62 (D.C. 1982); Holt v. Nelson, 523 P.2d 211, 217 (Wash. 1974).

[154] Bates, K., "CESAREAN SECTION EPIDEMIC: DEFINING THE PROBLEM--APPROACHING SOLUTIONS", 4 B.U. Pub. Int. L.J. 389, 400 (1995).

[155] Wright, *et al.*, *Federal Practice And Procedure* §5642, n. 1 and accompanying text.

[156] Wright, *et al.*, *Federal Practice And Procedure*, § 5644, n. 148 and accompanying text (citations omitted).

[157] *Wright, supra*, § 5642, nn. 54-57 and accompanying text (citations omitted).

One should resist the temptations of naiveté and acknowledge that the talk of trade secrets and confidential business information may well be used to "protect the public" from knowledge important to public well-being.

> Corporations have tried to use trade secret claims to conceal workplace hazards, the ingredients of harmful products, and discriminatory hiring practices as well as to prevent inspections by the Environmental Protection Agency, to keep information from unions that would assist them in carrying out their collective bargaining responsibilities, and to prevent the release of regulatory data. Although corporate lawyers made exaggerated claims about their fears of industrial espionage, there is probably cause to believe they were more concerned that the public would learn how their cozy relationships with federal agencies frustrated legislative efforts to protect the health and safety of citizens.[158]

ACOG materials are limited, for the most part, to its own members, with further dissemination prohibited. The author of this paper was denied access to ACOG committee reports and minutes of meetings relating to development of VBAC standards, despite a willingness to comply with any purchase requirements.[159] There appears to be no public library in the country that has a complete set – or anywhere near it – of ACOG-generated documents, including those consulted or developed in relation to the 1999 "reevaluation" of the VBAC standards in response to "malpractice suit" concern. The "anecdotal" evidence ACOG gathers on midwife-attended births with bad outcomes is not available to the public.

The July 5, 2001, issue of the New England Journal of Medicine contained a study and an accompanying editorial that focused international media attention on the VBAC issue and "set off a flurry of activity on internet sites and in doctor's offices all over the world."[160] The headlines suggested that new research supported repeat cesareans over VBAC, causing a number of physicians to opine that repeat cesareans were as safe or safer than vaginal birth. Less

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[158] *Wright, supra*, § 5642, nn. 213-221 and accompanying text (citations omitted, emphasis added).
[159] Personal communications with ACOG home office research service, July and August, 2007.
[160] Sheryl Stolberg, A Risk is found in Natural Birth After Cesarean, N.Y. Times, July 5, 2001; Rita Rubin, Vaginal Births After C-Section Risk Uterine Damage, USA Today, July 5, 2001; Deborah Josefson, Vaginal Delivery After

attention was paid to subsequent attacks on both the study and the Journal editorial, written by Michael E. Greene, M.D. The study contained "little new or groundbreaking-information and relied on questionable data collection."[161]

"[T]ake a closer look," wrote Jill MacCorkle, contending that overuse of medical intervention in childbirth has transformed ordinary vaginal birth into major surgery and arguing that a "careful critique exposes the limitations of the current medical model of childbirth and questions whether the model holds any credibility for women."[162] A noted critic of current obstetrical practice, Dr. Flamm, observed, "Even the charts of the women believed to have experienced uterine rupture, the very focus of this study, were apparently not available to for review."

As of this writing, Congress is considering the Healthcare Truth and Transparency Act of 2007, introduced in the House on May 10, 2007 by Rep. Jim McDermott, MD (D-WA) and Rep. John Sullivan (R-OK). The Act is touted as a major step forward in prohibiting misleading and deceptive advertising or representation in healthcare services, and will require certain healthcare providers to clearly state their qualifications. The bill also authorizes the nation's highest consumer protection body, the Federal Trade Commission (FTC), to take action against deceptive conduct. Ironically, however, the Act may actually exacerbate existing problems arising from medical monopolies and restraint of trade in the maternity care spectrum. Indeed, the industry reaction seems to acknowledge this, at least implicitly. For example, one trade group of licensed medical providers has lamented: "In this day and age, Americans are overwhelmed

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Cesarean Section Triples Risk of Uterine Rupture, BMJ website at http://www.bmj.com; Eric Dyson, ACNM Calls for Definitive VBAC Study, Press Release, American College of Nurse-Midwives, July 5, 2001.

[161] Jill MacCorkle, Fighting VBAC-lash: Critiquing Current Research, Mothering, Jan-Feb., 2002 available at http://www.mothering.com/11-0-0/11-4-0html/11-4-0/vbaclash.shtml.

[162] Jill MacCorkle, Fighting VBAC-lash: Critiquing Current Research, Mothering, Jan-Feb., 2002 available at http://www.mothering.com/11-0-0/11-4-0html/11-4-0/vbaclash.shtml.

with information regarding their healthcare options, whether through the media, or the Internet, or even word-of-mouth," said AAO-HNS Executive Vice President and Chief Executive Officer, David R. Nielsen, MD, FACS. "We want to make sure that patients and the general public are not being misled when they seek care. This means protecting those patients from individuals who are not being clear about the exact nature of their medical qualifications."

Joining the AAO-HNS in supporting the Healthcare Truth and Transparency Act are leading professional associations representing diverse physician specialties, including the American Psychiatric Association, the Academy of Ophthalmology, the American Academy of Orthopaedic Surgeons, the American College of Surgeons, the American Medical Association, the American Osteopathic Association, the American Society of Anesthesiologists, and the American Society of Plastic Surgeons.

Ironically, their preferred approach to ostensibly increasing transparency is not to increase public access to the inner workings of, and documents generated by, these organizations, but rather to create a new disclosure and anti-marketing onus for those outside the charmed College/Society circles: a public posting of "qualifications" which, according to traditional physician wisdom, could readily be spun as "disqualifications" to herd errant, overly-informed patients back into the physician fold.

Litigation. As discussed above, ACOG is already keenly sensitive to potential legal liability arising from the dreaded malpractice lawsuits. This aspect of its corporate sub-culture may be useful in procuring greater respect for, and compliance with, the human rights of women who come within the purview of ACOG practice bulletins, guidelines and practices.

Indeed, ACOG is certainly sophisticated enough not only to fear the law, but to know and use it:

> ACOG also uses fear of litigation to control doctors and hospitals. If doctors and hospitals go against one of their recommendations, they are more vulternable to litigation.[163]

Ob-gyns are already trained to fear the devil they know: malpractice lawsuits. They devil they don't know – but which could prove even more fearsome – is the human-rights lawsuit, for procural of patient consent absent full disclosure of the non-medical motivations embedded in American birthing recommendations, and in violation of consumers' right to unrestrained trade in the maternity-care field.

Conclusion

Current State Of American Birth Recommendations Violates International Human Rights Norms. "Everyone has the right to a standard of living adequate for … health and well-being". This is a generally accepted international norm. In the U.S., it is unduly difficult and dangerous for a woman to give birth, to seek freely her choice of maternity-care providers, and to do so on an informed basis. This endangers her health and well-being.

The International Covenant on Economic, Social and Cultural Rights "recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Patently, the U.S. has the resources to provide – and, in many medical specialties, does provide – the highest attainable standard of physical and mental health. Birthing is an exception, as demonstrated by disparity between c-section rates in the U.S. and other industrialized countries, the rate of unnecessary c-sections, and the maternal death rate.

According to WHO, "the right to health should be understood as extending beyond health care to access to health-related education and information, including on sexual and reproductive health." The secrecy surrounding ACOG standard-setting and underlying medical evidentiary

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[163] Wagner, M., *Born In the USA: How A Broken Maternity System Must Be Fixe To Put Women And Children First*, University of California Press, Berkeley, 2006, p. 27.

basis defeats efforts to provide an appropriate education, and full and fair information, to women faced with birthing decisions.

The Convention on the Elimination of All Forms of Discrimination against Women requires "all appropriate measures to eliminate discrimination against women…in particular to ensure…access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning". This has not occurred in the United States, due in significant part to ACOG's restriction of access to the information and motivations on which it relies to formulate national standards for maternal care and birthing options.

The Preamble to the Constitution of WHO provides: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The Convention on the Rights of the Child requires subscribing countries to "take appropriate measures to ensure appropriate pre-natal and post-natal health care for mothers". Both these standards are violated by the unnecessarily high American rate of c-section and maternal death, and the *de facto* discrimination against pregnant women in relation to their ability to make informed birthing choices, then seek and obtain the services they require.

Current State Of American Birth Recommendations Violates American Human Rights Norms. Every person has a liberty interest, constitutionally protected, in her own body. No person can be deprived of life, liberty or property without due process. Even with the belief that it is safer for mother and/or baby for birth to occur in a hospital, no action may be taken to interfere with parental choice unless there is a hearing, with adequate due-process safeguards,

forcing the accuser to carry the burden of proof, allowing both sides to be heard, and resulting in a hearing based on the evidence.

Every person is constitutionally entitled to a presumption of mental competence (comparable to presumption of innocence in criminal proceedings) until there is an adjudication -- meeting due process requirements -- to the contrary. There is no exception to this rule for pregnant women; they do not lose their legal presumption of mental competence by becoming pregnant.

A parent is presumed to be the legal representative of her child, unless and until the state -- in compliance with the due process clause -- terminates or restricts parental rights, including the right to make medical choices for her child. The general constitutional rule is that, unless a mother is proven to be "unfit", the state cannot interfere. If there are allegations of unfitness, such as abuse or neglect, the accuser must bring the appropriate charges and prove its case before interfering with maternal choice.

Therefore, a mother's right to make medical decisions for herself cannot be intruded upon except through proper adjudication, in compliance with the due process clause, that she is unfit to make those decisions. There is no legal principle that would by fiat exclude pregnant women from these rules of law.

Importance of Transparency As Partial Remedy. Since the founders' eighteenth-century antipathy to government restrictions on free speech, their ardor for the "enlightened choice of the people" has evolved into a broader romance with the free flow of information throughout society in general:

> All forms of exclusion and secrecy are inimical to the principles of openness and participation …. Rules that limit access, encourage secrecy or curtail participation must be strictly construed because they run counter to the great countervailing principles of

> openness and participation. A facile or insouciant resort to pragmatic remedies soon results in the tail wagging the dog.[164]

Rewarding the (presumed) superior intellect and investment of physicians via greater compensation and prestige, at the expense of pregnant women, does not justify current American birth practices.

> While it is true that our culture generally approves of persons whose cleverness enables them to surpass others, one has to look only to the "sucker-punch", the attack on Pearl Harbor, and the law of fraud to see that at some point this admiration for the clever passes over into sympathy for the justifiably ignorant. …. It would be enough to answer that we are all "free-riders" on the intelligence and effort of our ancestors.[165]

Importance Of Litigation As Partial Remedy. Certainly it is fashionable to deride lawyers (amongst whom the author counts herself), and to lament the "litigious nature" of our society, as doctors – particularly ob-gyns – are fond of doing, fomenting fear with talk of the "malpractice crisis" and other bogeymen. This is a red herring.

Defensive medicine is harmful to pregnant women. Ob-gyns exist to serve women, primarily pregnant women. Are we to believe that the ob-gyn specialty would cease to exist when the financial benefits outweigh the financial risk? This borders on the fatuous. In other words, despite the hue and cry orchestrated by the well-oiled ACOG political machine, ob-gyns are still making money they view as adequate to compensate them for their work -- or else we would have no ob-gyns.

Is it so radical to believe that practicing good medicine, rather than defensive medicine, would be its own reward, both financially and emotionally? As Dr. Wagner points out:

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[164] *Schwartz, et al. v. Celestial Seasonings, et al.*, Civ.Action No. 95-K-1045, Order Denying Motion To File Exhibits Under Seal (Document No. 93), Kane, J., (D.Colo. January 22, 1998) (articulating "my responsibility as a judge to avoid concealment of the judicial process form public view" at 1), citing *M.M. v. Zavaras*, 939 F. Supp. 799, 801 (D. Colo. 1996) (any privacy interest plaintiff had in remaining anonymous was "decisively outweighed" by the countervailing public interest in openness).

[165] Wright, *et al.*, *Federal Practice And Procedure,* sec. 5642, nn. 54-47 and accompanying text (citations omitted).

> Yes, most American obstetricians have been sued, and yes, there are high insurance premiums, but I don't believe these two realities are enough to explain obstetricians' extreme attitude. … In an obstetrician's daily world, everyone with whom he comes in contact looks up to him and follows his orders. In a courtroom, an obstetrician may even be looked down on. … [B]eing an obstetrician in the obstetric world is like living as an animal with no natural predators. A courtroom is not in the obstetric world. Predators lurk in the courtroom.[166]

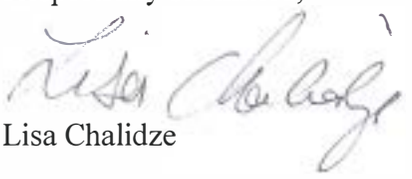
The rule of law is a fundamental value in this country. It forces people to account for their behavior. It is powerful and, for the most part, positive.

There is already a substantial body of law on medical malpractice. There is already a substantial constitutional jurisprudence on bodily autonomy and integrity.

Invocation of human-rights norms – both personal and economic -- in relation to American birth choices and services is the case yet to be brought, the plaintiff yet to be heard.

That means the jury is still out.

Respectfully submitted,



Lisa Chalidze

[166] Wagner, M., *Born In the USA: How A Broken Maternity System Must Be Fixe To Put Women And Children First*, University of California Press, Berkeley, 2006, p. 153.

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